THE IMPACT OF TRAINEE CHARACTERISTICS ON FAMILY THERAPY SKILL ACQUISITION OF NOVICE THERAPISTS

By

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Although researchers in the family therapy field have emphasized the need to assess the impact of family therapy training on trainees differing in experience levels, there has been limited study of this issue. The purpose of this study was to investigate the impact of the initial phase of family therapy training on novice therapists' skill acquisition. In addition, the associations between four types of trainee characteristics on the acquisition of these family therapy skills were examined.

The sample consisted of 99 students enrolled in introductory courses in structural/strategic family therapy drawn from five different academic training programs. Participants completed questionnaires assessing level of prior training and work experience in individual counseling and family therapy, preferred learning style, and knowledge of family therapy. The participants reported very limited amounts of prior training and work experience in either

individual of family therapy counseling. Of four possible learning styles, more than 50% of the participants described themselves as divergers.

Results indicated a significant change in skill acquisition from pretesting to posttesting on all three subscales of the Family Therapy Assessment Exercise (FTAE). Significant scores were obtained for the total score ($p < .0001$), the descriptive subscale score ($p < .05$), the conceptual subscale score ($p < .0001$), and the therapeutic score ($p < .0001$). The extent of initial knowledge of family therapy was significantly associated in an inverse direction with skill acquisition as predicted. No significant associations were found among prior training, prior work experience, or learning style and the acquisition of skills.

Regression analyses were conducted to examine the relationship between family therapy skill acquisition and prior training and work experience in individual counseling and family therapy, initial knowledge of family therapy, and preferred learning style. Changes in total skills and conceptual and therapeutic skills were significantly predicted only by the extent of initial knowledge of family therapy. In terms of trainee characteristics neither prior training and work experience nor preferred learning style were significant predictors.

Possible explanations and implications for these findings were discussed along with directions for future research in this area.

CHAPTER 1
INTRODUCTION

Over the past four decades, as the field of family therapy has expanded, opportunities to gain professional training in family therapy within academic settings have increased. This trend toward providing professional training in family therapy within academic settings is a relatively recent development. Most training in family therapy in the early stages of the field's development (the 1950s to 1970s) occurred in specialized research centers or free-standing institutes and was carried out primarily by innovative clinicians rather than academicians. Individuals receiving training during this early period usually had already received a terminal professional degree in one of the traditional mental health disciplines (e.g., social work, psychology, psychiatry, counseling) and viewed family therapy training as advanced, postgraduate skill training. During this time, only a small handful of universities offered marriage and family therapy graduate programs. These programs were typically at the doctoral level and only admitted persons who had earned a master's degree in one of the traditional disciplines.

In the past two decades, however, as a number of marriage and family therapy professionals trained during this earlier era moved into academic settings, opportunities for graduate education in family therapy have expanded. In addition, the master's degree rather than the doctoral degree has become defined as the standard for professional graduate education (Everett, 1979; Keller, Huber, & Hardy, 1988) by leaders of the American Association for Marriage and Family Therapy who, in the late 1970s, created a set of standards for professional education consisting of 2 years of graduate training coupled with an additional 2 years of supervised clinical practice. This set of events has resulted in the development of a significant number of master's level graduate degree programs in marriage and family therapy in departments of family and child development as well as within departments of social work and counselor education. More importantly, these events have resulted in a shift in the type of individual receiving such training. More often than not, a young novice-level therapist with little or no prior therapeutic skill training or work experience is the typical participant in these entry-level graduate training programs.

What are the implications of such a shift in the nature of the trainee and training context for the design and potential impact of family therapy training?

Interestingly, despite the growth in the provision of family therapy training in academic settings, there has been little empirical attention given to the implications of such a shift either in the design of or outcomes expected from family therapy training. Although researchers in the family therapy field (Gurman & Kniskern, 1978; Gurman, Kniskern, & Pinsof, 1986) have emphasized the need for those assessing the effectiveness of family therapy training to attend to the nature of the trainee as well as the training content, there is limited empirical evidence concerning the impact of entry-level graduate training in family therapy on young, novice-level clinicians who have had limited prior therapy training or work experience. Furthermore, very little is known regarding the types of pretraining differences in skills, personality attributes, or life experiences of students enrolled in entry-level graduate programs, and whether such pretraining differences have a differential impact on the acquisition of family therapy skills.

Scope of the Problem

Despite the dramatic growth in recent years in opportunities for family therapy training in both academic and nonacademic settings, there has been only limited attention given to examining the outcome of such training efforts. A review of the literature conducted by Gurman and Kniskern (1979) revealed no empirical evidence was

available in the field concerning the effectiveness of family therapy training. Moreover, at that time, no evidence was available concerning (a) the importance of prior professional training for persons entering family therapy training programs or (b) the merits of using any specific criteria for selecting trainees. By 1990 nine studies had been conducted evaluating the outcome of family therapy training; however, few advances had been made in specifying which trainee characteristics should be considered in trainee selection or evaluation (Avis & Sprenkle, 1990). Moreover, because most of these studies were conducted with populations of more experienced therapists and did not usually include information on or consider the impact of important trainee variables such as gender, experience level, or previous training, it has been difficult to determine whether the findings based on these populations can be generalized to novice-level professionals.

A number of reasons have been proposed for this slow rate of empirical progress in conducting family therapy training research. Avis and Sprenkle (1990) posited that a major source for this delay related to the difficulties inherent in conducting any type of psychotherapy training research. These difficulties concern (a) the complexity of the type of changes being measured; (b) the lack of a standard stimulus (i.e., clients vary) against which to

measure trainee's skills; (c) the lack of adequate and appropriate instruments for measuring trainee behavior and/or skill change; and (d) the lack of reliable knowledge about which therapist skills or behaviors are associated with positive therapy outcomes. In reviewing the state of the art of psychotherapy training research in general, Matarazzo (1978) attributed the slow rate of progress in such research to the following situation:

> We are attempting to measure a combination of conceptual, experiential, and behavioral learnings in a consistently shifting, never duplicated stimulus situation. We have poorly defined variables and inadequate measuring instruments that involve subjective judgments and whose use may not be comparable from one study to another. Because of the time-consuming nature of the measurement and treatment, the N in each study is likely to be small. Because of the complexity of the behaviors to be learned and the consequent complexity of the teaching program, not all aspects of the program are fully described nor are their effects measured. (p. 942)

A number of writers (Gurman, Kniskern, & Pinsof, 1986; Tucker & Pinsof, 1985) have reiterated these same difficulties in evaluating family therapy training. For example, in reviewing recent research on family therapy training, Avis and Sprenkle (1990) contended that current providers of family therapy training still know very little about the efficacy of any of their training approaches and that additional research needs to be conducted before they can speak with assured confidence about the nature of specialized training in family therapy. In commenting on

the lack of definitive research in this area, Gurman and Kniskern (1988) proposed a set of questions to guide future research. Among these was the following: "Which types of trainees profit most from what type of family therapy training experiences?" Other researchers concurred that a key issue in improving family therapy training efforts, as well as in developing a clearer understanding of the impact of training on professionals, centers on identifying those characteristics that predict positive training outcomes. Little is known, however, as to the pretraining differences in skills or experiences that exist among those who seek family therapy training, as there have been only a limited number of studies conducted in which the characteristics of the trainees have been examined in considering the impact of family therapy training.

Furthermore, most researchers in this area have utilized samples of experienced therapists or have employed mixed groups (i.e., have mixed experienced and novice-level professionals). For example, in a study conducted by Tucker and Pinsof (1984), changes in skills during the first year of study at the Center for Family Studies/Family Institute (CFT) of Chicago were investigated. The 19 trainees included in the sample were all practicing psychotherapists from various disciplines who had enrolled in a 2-year training program at CFT and were evaluated before and after their first year of training. Employing a

single group pretest-posttest design, the researchers investigated (a) clinical cognition, (b) in-therapy use of techniques, and (c) level of self-actualization. Clinical cognition was measured with the Family Concept Assessment (FCA) (Tucker & Pinsof, 1981), in-therapy technique with the Family Therapist Coding System (FTCS) (Pinsof, 1981), and self-actualization with the Personal Orientation Inventory (POI) (Shostrom, 1974). The in-therapy behavior of trainees was evaluated by rating the trainee's response to a "live-family" simulation. Four professional actors were trained to represent a family referred to therapy because the son had committed a petty crime. The training of the actors "was designed to enable them to improvise in response to each therapist, while maintaining the prescribed and consistent mode of family interaction" (Tucker & Pinsof, 1984, p. 441). In discussing the results, the authors suggested that trainees did not change significantly in the direction desired by the training staff on several dimensions. For example, the pretest-posttest scores showed a significant increase on only one of the three subscales of the FCA. This change indicated that trainees thought more in terms of circular rather than linear causality in the posttraining test than in the pretraining test. In-therapy verbal behaviors, measured by the FTCS, were expected to change in 25 code categories. However, only three of these changed significantly in the

expected direction, and one changed significantly in the unexpected direction. The POI showed no increase in self-actualization during the year of training. In attempting to interpret this finding, the researchers suggested that most trainees began the program highly actualized. Although the belief that family therapy training can have clinically meaningful effects on trainees was supported by the findings of this study, many directional hypotheses were not confirmed. This could indicate that the training had a more limited effect than many experts would have assumed or predicted or that only a longer period of training, or training of a different type, would produce the effects predicted on the other dimensions.

In another study, Breunlin, Schwartz, Krause, Kochalaka, Puetz, and Van Dyke (1989) examined the influence of three trainee characteristics (conjugal family experience, prior experience conducting family or individual therapy, and knowledge of family therapy) on the acquisition of family therapy skills for 96 trainees drawn from seven different structural/strategic training experiences. These seven training experiences utilized a mixed sample of both experienced and novice-level therapists drawn from a variety of different training contexts. Four of the training experiences involved agency-based and structured inservice training, and two involved graduate courses in family therapy. In two of

three settings the subjects had little prior clinical experience or training; in at least one of the remaining five settings trainees who had considerable clinical experience and training in family therapy were involved. Data from students in all seven programs were analyzed conjointly. No analyses were conducted regarding differences in trainee performance by program.

The acquisition of family therapy skills was measured by the Family Therapy Assessment Exercise (FTAE) (Breunlin, Schwartz, Krause, & Selley, 1983) in a pretest and posttest design procedure. The results of this study indicated that, as predicted, conjugal family experience was positively related and prior knowledge of family therapy was negatively related to performance (as measured by FTAE pretest-posttest change scores). Prior experience conducting individual therapy was also positively related to performance. However, because both the nature of the samples in this study and the nature of the training experience were quite mixed (with no information provided regarding either the actual levels of skills at pretesting and posttesting or differences in those levels among these various groups), it is difficult to draw conclusions as to how generalizable these findings are to novice therapists in the early stage of their professional training.

Despite such limited empirical investigation, it has been commonplace for family therapy trainers to assume that

not all trainees are suited for family therapy training. Factors often cited as considerations in selecting applicants for training programs are personal maturity factors (American Association for Marriage and Family Therapy, 1979; Everett, 1979; Nichols, 1979); cognitive abilities and academic credentials (American Association for Marriage and Family Therapy, 1979; O'Sullivan & Gilbert, 1989); previous professional training and/or work experiences (Breunlin et al., 1989; Kniskern & Gurman, 1988); preliminary knowledge of family therapy; and personal qualities (Everett, 1979; Sprenkle, 1988). However, these criteria for selection of applicants for family therapy training programs have typically been established more on the basis of tradition than any substantive empirical evidence.

Previous Professional Training and Work Experience

A number of researchers have emphasized the need to examine the impact of the trainee's previous professional training and work experience. Kniskern and Gurman (1988), for example, posed a series of questions regarding trainee professional experience. These were "What are the types of previous training that best prepare a trainee for family therapy training?" "Are there types of previous training experiences that inhibit training?" A number of researchers have attempted to address these questions. As noted earlier, in one of the few studies examining the

impact of trainee characteristics, Breunlin et al. (1989) examined the impact of prior individual therapy and family therapy training and work experience on trainee skill acquisition. They found that both prior training and work experience in family therapy were negatively related to performance. However, both prior training and work experience in individual therapy were positively related to performance in acquiring family therapy skills. This finding was considered surprising because it had been hypothesized by many family therapy trainers (Haley, 1981) that experience providing individual therapy would hinder the acquisition of family therapy skills. In another study, Zaken-Greenberg and Neimeyer (1986) reported the results of a controlled assessment of a training seminar in structural family therapy for university students. Changes in the conceptual and executive skills of 22 family trainees and 22 control subjects were assessed over a 16-week period using a repertory grid and videotaped therapy simulation technique. Results indicated significant gains in family therapy trainees but only among those with little previous exposure to family therapy. Difference in the overall number as well as type of intervention were also noted. Results generally supported the predicted impact of family therapy training with those having the least experience in family therapy demonstrating the most significant skill gains.

In the body of individual psychotherapy research literature Fielder (1950) reported that therapists, regardless of theoretical orientation, become more similar as experience increases. In addition, in more recent literature reviews, it has been noted that increasing experience facilitates the demonstration of therapy processes such as therapists' empathy (Auerbach & Johnson, 1977) and patient satisfaction (Beutler, Crago, & Arizmendi, 1986). Furthermore, Gurman and Kniskern (1978) cited therapist experience as a factor that influences the outcome of family therapy and suggested that training outcome studies that include this variable would be quite helpful.

Initial Family Therapy Knowledge

Researchers and trainers have emphasized the need to consider the trainee's initial level of knowledge of family therapy in assessing the impact of training. For example, Breunlin et al. (1989) reported that the higher the initial level of knowledge of family therapy, the smaller the skill changes from pretesting to posttesting as measured by the Family Therapy Assessment Exercise (FTAE).

Convergent/Divergent Thinking Style

Among the assumptions commonly used to select trainees has been the belief that certain relatively enduring personality factors such as divergent thinking, cognitive flexibility, and psychological-mindedness may influence the

trainee's success in family therapy skill acquisition. Attention has been given in the individual counseling and psychotherapy training literature to the impact of specific trainee attributes such as perceptual style, level of cognitive development, personal attitudes, personality characteristics, and preferred learning styles on the acquisition of counseling skills.

One particular variable that may have a significant impact on the acquisition of family therapy is the cognitive/learning style of the trainee. The trainee's mode of observing, taking in data about the world, organizing it, and acting upon it may influence the learning of family counseling/therapy skills just as it has been shown to affect other learning tasks (Lawrence, 1979).

A number of different cognitive style/learning style models and theories have been proposed. A well-known example is the Myers Briggs Typology based on Jung's theory of psychological types (Lawrence, 1979). Another is the model developed by Kolb (1976) based on the accommodator/ assimilator processes proposed by Piaget. These models have been used to sort individuals into different styles of resolving cognitive tasks. However, only limited research has been conducted using these learning style models in predicting learning of specific job related tasks such as counseling.

Underscoring this point, Mahon and Altman (1977) expressed concern that individual counseling skills training had been applied in a uniform manner that ignored both learner and learning process variables that could affect training outcome and counseling effectiveness. A body of research literature is being accumulated that supports their reasoning. It has been suggested that, in terms of therapy training, the level of success of counselors/therapists in training may be related to the compatibility between the cognitive styles of the trainers and those in training. For example, Handley (1982) examined the relationship between the similarity of cognitive styles of supervisors and counselors in training and supervision process and outcome measures. Using the Myers Briggs Type Indicator (MBTI) he found that intuitively oriented counselors in training received higher supervisor ratings than did other counseling students. Similarity between supervisors and counselors in training on the Myers-Briggs S-N (Sensing/Intuitive) scale was reported to be related to practicum student's satisfaction with supervision.

Yura (1972) also reported that feeling types predominated in a sample of master's level counselors in training. In another study, Wyse (1975) reported that the T-F (Thinking/Feeling) scale of Myers-Briggs Type Indicator (MBTI) differentiated between clinical and experimental

psychologists. Experimental psychologists showed more of a thinking orientation, whereas clinical psychologists showed more of a feeling orientation. Rouezzi-Carroll and Fritz (1984) found a predominance of feeling and perceptual types among allied health majors stressing client contact and empathy, and a predominance of thinking and judging types in fields stressing testing and critical analysis.

In a competing vein, however, Carey and Williams (1986) compared 18 supervisors and 46 counseling students in practicum training in terms of their dominant counseling style and related cognitive style. Instruments used included the Myers-Briggs Type Indicator (MBTI), the Counselor Evaluation Rating Scale (CERS), and the Barrett-Lennard Relationship Inventory (BLRI). The results of this study indicated there was a difference in cognitive styles between supervisors and counselors in training. Supervisors demonstrated a stronger thinking orientation and less variability on the sensing-intuiting scale than did counselors in training. However, no strong relationship was found between student scores on the T-F and S-N scales and process and outcome measures. These cognitive style factors in family therapy trainees have not been examined in any studies to date.

Kolb's theory of experiential learning has been used to explain the process of counseling and the process of individual counselor training, thus it is of particular

interest in this study. Kolb (1975, 1984) identified four modes of experience each of which involves an experiential learning cycle. According to Kolb, these four modes of experience--Concrete Experience (CE), Reflective Observation (RO), Abstract Conceptualization (AC), and Active Experimentation (AE)--must all be accessible to the learner to be effective as a counselor.

Abbey, Hunt, and Weiser (1985) have provided a perspective for understanding the counseling and counselor training/supervision process by means of Kolb's experiential learning model. They contended that Kolb's theory of experiential learning can be used to describe (a) the sequence of counseling; (b) the variations in interpersonal response of clients, counselors, and counselor trainees; and (c) how such variations affect the counseling and training process. Moreover, Abbey et al. suggested that, to be fully functioning and effective, counselors must have access to all four modes of experience in their dealings with clients. However, because counselors typically have preferred modes of operating, one of the purposes of counselor training is to assist the counselor in becoming more aware of his or her underdeveloped mode of operating and how such imbalances may influence the delivery of counseling services and the acquisition of counseling skills. For example, an individual who prefers to operate from a cognitive stance

(abstract conceptualization) may have ease in adopting a cognitive or rational/emotive counseling approach but may have to attend to not using that mode to the exclusion of the awareness of his or her own feelings. Conversely, those counselors who prefer to operate from an experiential mode (CE-Concrete Experience) must be concerned with not doing so to the exclusion of their own analysis and their own implicit theory regarding the client's feelings, reflections, thoughts, and actions. Thus, although trainees will find counseling operations and theories that are congruent with their own dominant modes (i.e., Reflective Observation (RO) dominant trainees may prefer a Rogerian stance whereas an Active Experimentation (AE) dominant trainee may prefer to operate from a Gestalt position), they will need to have available a broader array of ways of operating on the world to be most effective with a wide variety of clients. Similarly, with family therapy (e.g., a structural family therapy approach versus a Bowenian approach) preferred methods of operating may hinder the development of particular family therapy approaches and facilitate the acquisition of other approaches. Consequently, a match between the learning mode demanded in a particular training model and the preferred learning mode of the trainee may benefit the trainee's acquisition of skills in that model. Identifying a trainee's preferred learning style and focusing on how it

may facilitate or hinder acquisition of skills in family training may have significant implications for understanding the impact of a particular family therapy training experience.

Need for the Study

Researchers are now offering evidence that training does affect change in trainees on some important dimensions (Breunlin et al., 1983; Hernandez, 1985; Pulleyblank, 1985; Tucker & Pinsof, 1984). However, there is a need to examine more closely how trainee characteristics impact on the teaching and learning process particularly in novice therapists. Reinforcing this perspective, Gurman and Kniskern (1988), as well as Breunlin et al. (1989), suggested that researchers shift from asking the general question "Does family therapy training work?" to asking more specific questions such as "How do specific trainee characteristics influence (i.e., either facilitate or inhibit) a trainee in learning marriage and family therapy?" (p. 375). They proposed that specific trainee characteristics be examined that are not model specific but are general variables assumed to enhance the learning skill acquisition process across various family therapy training models. However, to date, only two studies (Breunlin et al., 1983; Tucker & Pinsof, 1984) in the marriage and family therapy training research literature have addressed

the contribution of trainee characteristics to the training/learning process.

It is not surprising that this specificity question in the field of family therapy training has not been addressed, because the parallel question in the general counseling and psychotherapy training field has also been extremely difficult to answer.

Purpose of the Study

The purpose of this study was twofold. First, the impact of the initial phase of family therapy training on novice therapists' skill acquisition was assessed. Second, the impact of four types of trainee characteristics on the acquisition of these family therapy skills was examined. The four types of trainee characteristics were (a) extent of trainee's prior training in individual therapy and family therapy, (b) extent of trainee's clinical work experience in individual therapy and family therapy, (c) extent of initial family therapy knowledge, and (d) trainee's preferred learning style.

Research Questions

In this study the following research questions were addressed:

1. How can students in the initial phase of family therapy training be characterized in terms of
    a. their age,

b. their prior training experiences in individual therapy,
c. their prior level of work experience in individual therapy,
d. their prior training in marriage and family therapy,
e. their prior level of work experience in marital and family therapy,
f. their initial level of family therapy knowledge, and
g. their preferred learning style?

2. What is the impact of the initial phase of structural/strategic family therapy training on the acquisition of family therapy skills by student therapists?

3. To what extent does that level of initial knowledge of family therapy affect the amount of skill acquisition demonstrated by student therapists?

4. To what extent does prior individual counseling training inhibit the acquisition of family therapy skills of student therapists?

5. To what extent does prior family therapy training inhibit the acquisition of family therapy skills of student therapists?

6. To what extent does previous work experience conducting individual therapy inhibit the acquisition of family therapy skills of student therapists?

7. To what extent does previous work experience conducting family therapy inhibit the acquisition of family therapy skills of student therapists?

8. To what degree does the learning style of the therapist influence the acquisition of family therapy skills of student therapists?

9. To what extent do the trainee characteristics of prior training experience in individual therapy or marital and family therapy, prior work experience in individual therapy or marital and family therapy, initial knowledge of family therapy, or preferred learning style influence the acquisition of family therapy skills of student therapists in the initial phase of structural/strategic family therapy training?

Context for the Study

Students enrolled in university-based graduate level training programs in marriage and family therapy that were accredited by or eligible for accreditation by the Commission on Accreditation for Marriage and Family Therapy Education were recruited for participation in this study. Only those trainees involved in the entry-level phase of training in structural/strategic family therapy were targeted for inclusion. Typically, the objectives for this

beginning phase of training include (a) acquainting the student with the basic concepts of family systems theory and the historical development of these ideas; (b) introducing the student to the structural/strategic model of family systems therapy, its related concepts and intervention methods; (c) introducing the concept of differing family forms (i.e., single parent families, dual career families, etc.); (d) introducing the concept of family life cycle issues; (e) assisting the student in developing skills necessary to assess families (i.e., collect, observe, and organize family interactional data) in order to plan counseling interventions; and (f) providing students with an opportunity to rehearse family interviewing and assessment skills (E. Amatea, personal communication, March 18, 1989).

Significance of the Study

Examining the type of skill development of novice therapists during the initial stages of family therapy training can be useful in the ongoing refinement of family therapy training experiences in academic contexts. Moreover, ascertaining which trainee variables are vital to consider in predicting learning among younger professionals can be helpful in shaping both selection and training design decisions and policies. Traditionally, professionals involved in providing psychotherapy training have had difficulty in defining what skills or aptitudes

are relevant predictive factors for performance as a therapy professional. Although scores on the Graduate Record Examination (GRE) and college grade-point average (GPA) are of value in predicting graduate student academic performance, there have been no established indices for predicting student clinical performance. The identification of factors useful in predicting clinical skill development could make for a more efficient use of academic training resources, as well as begin to address the question of who is most likely to benefit from specific graduate level family therapy training experiences.

Definition of Terms

Family therapy training refers to the beginning phase of training in family therapy at university-based graduate level training programs. This phase of training emphasizes the acquisition of observational, perceptual, and conceptual family therapy skills as originally defined by Cleghorn and Levin (1973). The training segment consists of a 16-week semester long course (48 hours) or its equivalent in a quarter hour system in family therapy that emphasizes the structural/strategic school of family therapy.

Learning style is defined as the extent to which an individual emphasizes abstractness verses concreteness and action versus reflection in responding to the world. This

definition of experiential learning theory is based on the work of Kolb (1976, 1981).

Family therapy skills refers to those observational (perceptual), conceptual, and technical (therapeutic) skills needed to conduct structural family therapy. Observational skills are those skills required to perceive and describe behavioral interactions within a family session (Breunlin et al., 1983). Conceptual skills are those skills that relate to the therapist's ability to understand a theoretical model that enables a therapist to classify distinctions according to that model (in this case a structural/strategic model) (Breunlin et al., 1983). Therapeutic skills are those skills that refer to the therapist's ability to act in family sessions in ways that are consistent with goals of the training program (Breunlin et al., 1983).

Student therapist refers to graduate students enrolled in counselor education, counseling psychology, or marriage and family therapy departments of universities located in the northeast and southeast regions of the United States participating in graduate-level courses in structural/ strategic family therapy.

Extent of prior training refers to the number of graduate-level courses in individual counseling and marriage and family therapy completed by the trainee and

the number of supervision hours received in individual counseling and marriage and family therapy.

Extent of prior work experience refers to the number of years spent in providing either individual counseling or marriage and family therapy.

Level of initial knowledge refers to the student trainee's initial degree of knowledge of observational, conceptual, and therapeutic family therapy skills as measured by the Family Therapy Assessment Exercise (Breunlin et al., 1983).

CHAPTER II
REVIEW OF THE LITERATURE

This chapter provides a review and analysis of the theoretical and research literature on family therapy training. The review addresses three major areas: (a) family therapy training, (b) structural and strategic models of family therapy practice and training, and (c) student characteristics expected to impact skills training.

Historical Perspective

In a state of the art review of the literature on family therapy training and supervision, Liddle and Halpin (1978) cited almost 100 references that dealt with some aspect of training. They suggested that these studies lacked rigor. Only one-fifth of the articles focused on the evaluation of training, and none of these were empirical studies. These articles documented a variety of attempts to assess training outcome through such means as videotape assessment or playback and measuring changes in trainees' work patterns and job related behaviors.

In 1984, Tucker and Pinsof noted that most positive reports of training outcomes

> have been based primarily on clinical impressions . . . or trainee self-reports at post training . . . unfortunately, these positive conclusions rest on the tacit and untested assumption that a self-reported, positive training experience is

> associated with a change in actual practice or outcome with patients. (p.437)

They noted that no research evidence existed to show that training in marital and family therapy increased clinical effectiveness.

Although research examining the impact of family therapy is growing (Gurman, Kniskern, & Pinsof, 1986), little empirical work has been done to evaluate the outcomes of family therapy training. Difficulties inherent in this type of research are the reason for the delay. These difficulties also characterize the outcome research in individual psychotherapy training. Matarazzo (1972) identified several of the difficulties confronting individual psychotherapy training researchers. These included problems with design, randomization, simulation techniques, use of real clients, poorly defined variables, inadequate measuring instruments, and small samples.

In one of the first empirical evaluations of a family therapy training program, Tucker and Pinsof (1984) reiterated these same difficulties in evaluating family therapy training. They reported four factors confounded the evaluation process. They were (a) complexity of the type of changes being measured; (b) the lack of a standard stimulus (i.e., families vary) against which to measure trainee's skills; (c) the lack of adequate and appropriate instruments for measuring change; and (d) the lack of reliable knowledge about which therapist skills or

behaviors are associated with positive family therapy outcomes.

Family Therapy Training Research

In 1979 Kniskern and Gurman reviewed the status of research on family therapy training and revealed the field's lack of empirical studies of family therapy training. In a more recent review, Gurman and Kniskern (1988) noted that, despite the tremendous upsurge in family therapy training over the past decade, there is still little research to guide these training efforts. Breunlin et al. (1989) reported that "with few exceptions . . . training programs do not evaluate themselves, but rather do what they consider to be correct, often basing their training decisions on some isomorphism between therapy and training domains" (p. 2).

Two different bodies of research literature of interest to the family therapy training researcher are developing. One concerns therapist factors that influence the outcomes of family therapy. The other concerns empirical evidence for the effectiveness of family therapy training. The literature on each of these topics is reviewed in the following sections.

Research on Therapist Factors Affecting Treatment Outcome

At the time of their review of the family therapy training research literature in 1978, Gurman and Kniskern noted that the research consisted of limited empirical

evidence as to the effectiveness of family therapy. However, a number of studies existed (e.g., Epstein, Segal, & Rakoff, 1968; Thomlinson, 1973; Tomm & Wright, 1979) in which the specific therapist factors that influence the outcome of family therapy were examined. Three of the most important therapist factors associated with positive therapy outcome were therapist experience level, structuring skills, and relationship skills. High levels of experience have been reported to be positively associated with positive therapeutic outcome, thus the behavior of experienced therapists can be an indirect criterion for training success. Pinsof (1981) reported that advanced therapists used a wider range of interventions and were significantly more active than beginners. In 1984, Tucker and Pinsof provided preliminary evidence that trainees became more active and used a wider range of interventions over the course of training. More specifically, they noted that training had a significant impact on trainees in terms of increased systemic thinking, increased activity level, and increased range and specificity of interactions.

Therapist structuring skills have also been investigated by researchers (Alexander, Barton, Schiavo, & Parsons, 1976; Sigal, Guttman, Chagoya, & Lasry, 1973; Sigal, Rakoff, & Epstein, 1967). These include skills such as directiveness, clarity, self-confidence, information

gathering, and stimulating interaction. Gurman and Kniskern (1988), for example, argued that the family therapist must be active and provide early structure without assaulting family defenses too soon. Alexander et al. (1976) reported the finding of the importance of structuring skills that supports other research findings that active family therapists have fewer dropouts than nonactive, and that providing structure early in therapy while not attacking family defenses prematurely is associated with good outcome (Gurman & Kniskern, 1978; Postner, Guttman, Segal, Epstein, & Rakoff, 1981).

Finally, therapist relationship skills, including warmth, humor, and affective-behavior integration, have received consistent support as a skill related to positive outcome. Several investigators (Shapiro, 1974; Shapiro & Budman, 1973; Waxenburg, 1973) have reported that therapist empathy, warmth, and genuineness appear to be very important in keeping families in treatment beyond the first interview. Alexander et al. (1976) reported, for example, that both structuring skills and relationship skills were factors related to positive outcome regardless of the theoretical orientation. Together these variables accounted for 60% of the outcome variance in family therapy in their study. These same skills have also been found to be critical for the process of effective psychotherapy in general.

Research on Family Therapy Training

The second body of literature reviewed concerns the empirical studies of the effectiveness of family therapy training. Noting a lack of empirical evidence in this area, Gurman and Kniskern (1979) outlined a five-step process by which trainers could structure their evaluation efforts. This process includes the following: (a) identification and specification of training goals, (b) development of a training model, (c) development of measures that can evaluate training-induced change in trainees who participate in the program, (d) demonstration of measures that can evaluate training induced change, and (e) demonstration that trainees who have shown expected change on the measures are better able to help families in therapy. This five-step process was proposed as a model to evaluate any training program.

Obviously, the goals and identified outcomes of training and supervision (and the skills of the supervisor) are dependent upon the theoretical orientation of the particular training program involved. Models of family therapy tend to be isomorphically represented in their corresponding training models and methods. For example, the experientially oriented (Constantine, 1976; Ferber & Mendelsohn, 1969; Luthman & Kirschenbaum, 1974) and psychodynamically based programs (Ackerman, 1973; La Pierriere, 1977) tend to emphasize personal growth aspects

of training and affective experiences of the trainees. Whereas, those programs that operate more from a structural (Minuchin, 1974), behavioral (Cleghorn & Levin, 1973), or strategic (Haley, 1976) therapeutic orientation have more cognitively-based goals and are focused more on defining particular sets of therapist skills and ways of intervening in dysfunctional systems. According to Garrigan and Bambrick (1976), a current trend in the family training literature is toward establishing operationally defined objectives and therapist competencies.

Cleghorn and Levine (1973) proposed a model for operationalizing objectives for assessment of training in family therapy. According to their model, therapist skills can be classified into three groups: perceptual, conceptual, and executive. Most published accounts of training programs have described their goals as achieving an increase in trainee's conceptual, perceptual, and technical or executive skills. This way of describing learning objectives (e.g., Falicov, Constantine, & Breunlin, 1981; Tomm & Wright, 1979) follows the proposal of Cleghorn and Levine.

Conceptual skills are those that relate to the therapist's ability to formulate problems systemically and to understand the way rules govern family behavior and make family interactions predictable. Thus conceptual skills basically involve what the therapist thinks about in a

therapy session and how those thoughts are organized. Conceptual skills can be evaluated by paper and pencil methods.

Perceptual skills are those skills that relate to a therapist's ability to evaluate a particular family within his or her conceptual framework. Perceptual skills refer to what the therapist observes in a family session, how the therapist perceives interactions, and their meaning to and effect on family members. Thus to evaluate perceptual skills, the therapist must be presented with family behavior, whether live or recorded. Conceptual and perceptual skills seldomly occur independently of one another. More discriminating perceptions allow for better conceptualization, and better conceptual skill allows for better perceptual acuity.

The third type of skill is called executive or technical skill. This refers to the therapist's ability to act in family sessions in ways that are consistent with the goals of the training program. Thus executive skills involve what the therapist says and does in the therapy session in order to influence the family's sequences of transactions and thus alter the way the family functions. These skills are the ultimate goal of training, although the more immediate goal in training is to increase conceptual and perceptual skills.

Prior to 1979, most of the family therapy training literature consisted of articles that described training programs and discussed training and supervision goals (e.g., Ferber, Mendelsohn, & Napier, 1972; Flomenhaft & Carter, 1974; Garrigan & Bambrick, 1977; Lange & Ziegers, 1978; Liddle & Halpin, 1978). Typically, evaluation of these programs took the form of uncontrolled post hoc studies in which the change measures used were reports of the level of services offered to families at the respective mental health and counseling centers. For example, Flomenhaft and Carter (1974, 1977) mailed questionnaires to professionals in private practice one year after termination of a 20-week training program in structural family therapy practice. A significant increase in direct service to families versus individuals was noted.

During the period from 1979 to 1985, much of the training literature continued to be impressionistic, although there was a trend to objectify the skills of family therapy trainees. For example, many of the studies described training outcomes based on clinical observations of the trainees (e.g., Aponte & Van Deusen, 1981; Beal, 1976; Ferber & Mendelsohn, 1969, Nichols, 1979) or provided a sociological comparison of supervision methods based on trainee self-reports (e.g., Tomm & Leahey, 1980).

Methods of assessment in the family therapy training literature have ranged from self-report to simple computer

scored behavioral counts. A popular method of assessing trainees knowledge of family therapy course content and theory involves paper and pencil methods such as multiple choice questions or essays (Friedman, 1971; Tomm, 1980). Friedman reported that mental health professionals significantly increased in factual and theoretical knowledge between pretraining and posttraining tests. Tomm reported that first year medical students demonstrated significant increases in the knowledge of a Family Categories Scheme devised by Epstein and his associates following their training experiences (Epstein, Sigal, & Rakoff, 1968).

Another method used in the family therapy training literature involves assessing changes in attitudes of the trainee. Pollstra and Lange (1978) reported that trainees' attitudes shifted significantly towards acceptance of behavioral family therapy as a result of training in this model. And, as previously mentioned, Flomenhaft and Carter (1974, 1977) reported that mental health professionals trained in family therapy reported a significant increase in the amount of time spent in family therapy. These findings suggest that training leads to an increased knowledge of course content and an acceptance of new theoretical positions but, in fact, offer little more than assurance that professionals can learn new concepts and may

be more apt to use those concepts with increased familiarity.

There are two major limitations of the empirical research discussed so far. Typically the research design did not include comparable control groups. Thus any changes in the trainees could be attributed to factors other than training programs, for example, spontaneous improvement or maturation attention placed effects (Cook & Campbell, 1979). In addition, the variable selected as outcomes measured only whether trainees had assimilated instructional material not whether they could demonstrate particular family therapy skills.

Another aspect of the training research concerned the development of measures of change. Some of the earliest studies used coding systems (Postner et al., 1981; Sigal et al., 1973; Sigal, Lasry, Guttman, Chagoya, & Pilan, 1977). Pinsof (1981) pointed out that the main difficulties with these studies arose from the coding system. Specifically, the division of therapist's verbal behavior into two categories of drive and interpretation makes the system not sensitive to find significant results.

In 1974, Chagoya, Presser, and Sigal developed a more specific coding system using 26 distinct categories. They conducted two studies using this system. In their more recent study, Sigal et al. (1977) examined the relationship between family therapy trainees' reactions to a videotaped

simulated family session and the outcome of therapy of families they treated. Trainees' behaviors were coded in the simulated situations and results were compared with family outcome data. Outcome was based on independent ratings of the family's satisfaction with treatment, the status of the presenting problem six months after termination, return to treatment, and the family's goal attainment scores.

Through the use of this category system (FTIS-II), the authors distinguished different levels of competence among therapists and, in some cases, showed that families who saw more expert therapists had better outcomes in therapy. The main difficulty with this research was its failure to establish whether results shed light on the process of actual family therapy because results measured the therapist's response to a simulated videotaped family session versus actual in-therapy behavior.

Clearly the closer one gets to the evaluation of real therapy the more powerful the instrument or measure of effectiveness. However, very practical problems arise in the use of "real families" in actual sessions. These can include lack of standardization, no shows, and confidentiality issues. Because of these difficulties researchers have used written descriptions of family behavior and simulated family sessions.

As previously noted, these problems are also not new to the history of outcome research in individual psychotherapy. Matarazzo (1972) summarized difficulties with individual psychotherapy training research that still apply today. These include problems with design, randomization, simulation techniques, and the use of real clients.

Pinsof (1977) and Allred and Kersey (1977) also developed instruments to assess behavioral changes in family therapists. These instruments targeted therapist executive skills. Pinsof (1979) developed a 19 category, nominal coding system used to study short-term, problem oriented family therapists during initial interviews. Researchers using his system have reported findings of differences in verbal behavior of advanced family therapists who focused on the here-and-now and beginners who were more focused on individual members' thoughts and opinions. Pinsof speculated that two cognitive skills--"sequential thinking" and "attentional skill"--may influence the difference between two groups.

Following this study Pinsof (1981) developed a more complex coding system called the Family Therapist Coding System (FTCS). This system consisted of nine nominal scales, each one containing a number of distinct categories and, in some cases, subcategories. A therapist intervention is coded on each scale and this allows for a

reconstruction of a therapist's intervention. Thus one can get a clearer picture of a therapist's verbal behavior. However, there is a major limitation involved in the use of this measure. Due to the complexity of this instrument, a considerable amount of practice administration is required in order to insure reliable measurement and, therefore, the use of the FTCS is often not feasible.

In the second measure, Allred and Kersey (1977) have analyzed results of research using the Allred Interactional Analysis of Counselors (AIAC). This measure has also been shown to differentiate among trainees' level of training. Several researchers have reported this measure of verbal behavior to be highly reliable (Kersey, 1976; Sanders, 1974; Watson, 1975). However, studies attempting to establish concurrent validity have not been impressive.

In the past 8 years several excellent descriptions of the development and validation of therapist rating scales have been published (Breunlin et al., 1983; Piercy, Laird, & Mohammed, 1983; Tucker & Pinsof, 1984). In each of these papers a different approach to the problem of scale development was detailed.

For example, Piercy et al. (1983) began with a pool of 375 items that were believed to reflect family therapy skills from all theoretical orientations. Experienced family therapists repeatedly reduced the pool until it became 10 items in each of 5 skill categories. It was

developed to evaluate the therapeutic skills of trainees as well as therapists. Their goal was to create a short, concise instrument. The categories were based on the structuring and relationship skills specified by Barton and Reed and on Levant's classification of various theoretical models of family therapy (Piercy et al., 1983).

Mohammed and Piercy (1983) used the relationship and structuring scales of this coding system to measure the effectiveness of two methods of training. They compared an observation feedback method of training (i.e., trainees discuss videotapes of their simulated family therapy sessions) with a skill-based method (i.e., the trainer shows videotapes that teach relationship skills and structuring skills). Twenty-six subjects participated in the study. Both groups received both treatments in a different order. A significant result occurred in the group that first received observation feedback followed by skill based training. This group showed a significant increase in relationship skills.

In another study, Tucker and Pinsof (1984) utilized a scale (the Family Therapist Coding System) that was developed to allow for the description of all therapist behavior. The Family Therapist Coding System was based on the research previously discussed conducted by Pinsof (1979, 1981).

Breunlin et al. (1983) also reported the development of an instrument designed to measure observational (perceptual), conceptual, and technical (executive) skills of family therapy. The original instrument consisted of a videotape of an enacted family's first session and a series of multiple choice questions regarding the subject's perceptions, conceptualizations, and therapeutic recommendations about the tape. The experimental subjects consisted of 22 psychiatric residents who were given one month of family therapy training, and the control group subjects consisted of 11 pediatric residents who were not given family therapy training or any formal training in psychotherapy. A preassessment-postassessment revealed a significant increase in conceptualizations skills for only family therapy trainees. There were no significant changes in either observational (perceptual) or technical (executive) skills for either group. Breunlin and colleagues suggested that the instrument may not have been sensitive enough to detect a change in skill level.

The FTAE has since been revised. The fifth refinement is currently being used in research studies. The current version is a procedure in which subjects watch a simulated family therapy interview on videotape and answer the questions of a 32-item multiple choice format test. Breunlin et al. (1983) pointed out that a multiple choice format in which subjects choose an alternative in response

to a simulated videotape constitutes a reasonable compromise in that it can reliably measure therapist skills within a standardized and easily scorable methodology.

The FTAE was designed to assess the acquisition of skills within the structural/strategic model. Although Breunlin et al. (1983) reported continued difficulties with the observational (perceptual) scale, there is accumulating evidence that both the conceptual and therapeutic scales of the current version of the FTAE discriminate well, as does the total score (Hernandez, 1985; Pulleyblank & Shapiro, 1986; West, Hosie, & Zarski, 1985). For example, Hernandez (1985) tested the descriminant validity of the FTAE using a sample of 75 persons who were either novice, mid-range, or experienced family therapists. Subjects were drawn from seven family therapy training programs in Illinois and Indiana and ranged from first year graduate students to AAMFT approved supervisors. Three- and six-week test-retest reliabilities were .76 and .62, respectively. Hernandez found that the total score, conceptual score, and the therapeutic (executive) score discriminated well between novice and experienced therapists.

In another study, Pulleyblank and Shapiro (1986) used the FTAE to evaluate a 9-month structural family therapy training program and found that all the scores of the FTAE differentiated between nine trainees in a structural family

therapy training program and an eight member comparison group.

All 9 trainees held master's degrees in either marriage and family therapy or social work and were employed at a mental health agency. The comparison group were educated as master's level marriage and family therapists and were also employed as such. However, generalizability of the study was limited due to the small sample size.

In another study, West et al. (1985) examined 10 students enrolled in a graduate level course in family therapy who practiced interviewing simulated families over a period of 4½ months (one semester). Students were novice level family therapists. Skill development was assessed at three equal interval times during the semester. The FTAE was used to measure skill development. A repeated measures analyses indicated there were significant differences between testing times on the total score. Significant differences were found from time 1 to time 3 with combined scores for observational and conceptual subtests. Conceptual skills increased significantly from time 1 to time 2, while observational skills significantly increased from time 2 to time 3.

No significant differences were found for the therapeutic subtest. This may be due to two factors: the test instrument and the method of training that emphasized

observational and conceptual skills. However, the study lent support to the validity of the FTAE and suggested the use of simulation for skill development of observational and conceptual skills.

Evaluation of Training Studies

Recently, some researchers have evaluated training programs. Tomm and Leahey (1980) examined the relative effectiveness of differing methods of training used to teach basic family assessment to 72 first year medical students at the University of Calgary. Three teaching methods were compared: (a) lecture with videotaped demonstration, (b) small group discussion with the same videotaped demonstration, and (c) learning groups that included the experiential component of interviewing and assessing a family and presenting a videotape of the interview to the group for discussion. Results showed that posttest achievement was significantly higher than pretest for all methods. However, no method was shown to be superior to others, leading to the conclusion that the lecture-demonstration approach is the method of choice for teaching family assessment to beginning medical students, on the basis of cost-effectiveness.

An outcome study of the effectiveness of a 3-day training workshop designed to teach basic family therapy skills was reported by Churven and McKinnon (1982). A pretest-posttest design was used to compare 24 trainees'

performances before and after the workshop on both cognitive and intervention skills. Written case analyses, videotaped interviews with simulated families, and self-ratings were the three measures used to evaluate trainee's learning. Significant improvements were found on all three measures. No significant differences were found between different professional groups participating. Changes in cognitive and intervention skills were found to be relatively independent.

Byles, Bishop, and Horn (1983) described the evaluation of a 14-month training program based on the McMaster model of family functioning. The program consisted of 6 months of training in conceptual and perceptual skills and 8 months of training in executive skills through peer group review of audio-taped therapy sessions. Twenty-four social workers employed by a metropolitan family service agency were the trainees. Outcome measures of skill acquisition were inconclusive. The most significant result was greatly increased use of family therapy by agency staff. However, this article is important as a case study in program innovation within an agency setting.

As previously mentioned, Mohammed and Piercy (1983) examined the differential effect of two training methods (observation feedback and skill based) as well as the sequence of these methods, on structuring and relationship

skills. The training consisted of four weekly 2½ hour sessions. Relationship skills improved with the observation feedback methods in the first sequence. However, overall, neither of the methods or sequences were more effective in direct comparison.

The first comprehensive study of an outcome evaluation of an entire training program was reported by Tucker and Pinsof (1984). They demonstrated that training does effect change in trainees on several important dimensions. Setting as their goal evaluating to what extent psychotherapy training programs achieve their skills training goals, Tucker and Pinsof developed a standard stimulus and a battery of instruments for evaluating trainee change. The study evaluated change in 19 family therapy trainees in their first year of study at the Center for Families Studies/Family Institute of Chicago (CFS/FIC) in terms of three attributes: (a) clinical cognition, (b) techniques, and (c) self-actualization. Training involved part-time, post-graduate coursework. Clinical cognition was measured by the Family Concept Assessment (FCA) (Tucker & Pinsof, 1981) and self-actualization by the Personal Orientation Inventory (POI) (Shostrom, 1974). The in-therapy behavior of the trainees was evaluated by rating the trainee's response to a live family simulation. Professional actors were used to represent the family. Two different but similar families were used for pretesting and

posttesting. Simulated families were equivalent in interactional patterns for trainees as demonstrated by empirical evidence.

Results reported by Tucker and Pinsof (1984) suggested that trainees did change significantly on several dimensions in the direction desired by the training staff. Specifically, pretest-posttest scores showed a significant increase on one of the three subscales of the Family Concept Assessment. This change indicated that trainees thought more in terms of circular rather than linear causality at the posttesting than at the pretesting. In-therapy verbal behavior, as measured by the Family Therapist Coding System, was expected to change in 25 code categories. Of these, three were found to have changed significantly in the expected direction. The POI showed no increase in self-actualization during the first year of training but also suggested that most trainees began the program highly actualized.

Tucker and Pinsof's (1984) findings supported the belief that family therapy training can have clinically meaningful effects on trainees. Increased systemic thinking, increased activity level, and increased range and specificity of interactions were impacted by training. This study broke methodological ground and provided a model for future investigation as it illustrated that empirical study of family therapy training is possible and confirmed

the fact that research may be useful as a guide for shaping family therapy training programs.

In 1986, Zaken-Greenberg and Neimeyer reported the results of a controlled assessment of a training seminar in structural family therapy for graduate students. Changes in the conceptual and executive skills of 44 therapy trainees (22 family trainees and 22 control subjects) were assessed over a 16-week period using a repertory grid and videotaped therapy simulation technique. Results indicated significant conceptual gains in family therapy trainees but only among those with little previous exposure to family training. Differences in the overall number as well as type of interventions were also noted. Results generally supported the predicted impact of therapy training but left unanswered questions regarding the unique input of family therapy training over individual training. Family therapy training itself could not be isolated as the cause for many of the differences noted in this study. For example, some effects such as decrease in obstructive responding occurred in both groups suggesting that they may result from practice, maturation, or some other variables not specific to family therapy training per se. Other findings in the study demonstrated the consistent superiority of family trainees (e.g., number of interventions generated, effects that did not vary with training). Again these findings raised questions regarding the unique impact of family

therapy over and above individual training. Moreover, these authors noted that there was an uncertain relationship between training effectiveness and therapeutic effectiveness. Even though the structural family trainees in this study did show comparatively greater gains in conceptual and executive skills, no current research has specified the impact of training gains on therapy outcome.

The following conclusions can be drawn from reviewing this literature: (a) instruments with some degree of reliability and validity now exist that distinguish therapists experience levels; (b) family therapy training appears to produce an increase in trainee skill acquisition, however intervention skills have never been measured in actual therapy sessions; (c) cognitive and intervention skills appear to develop independently of one another; and (d) beginning assessment skills may be effectively taught using traditional classroom methods.

With regard to the type of trainee, the context and type of trainee, and the length of training, this body of research demonstrated a great deal of diversity. For example, types of trainees included graduate students, post-master's level trainees, medical students, and mixed professional groups. Context for training included a professional workshop, graduate level coursework, family therapy training centers, in agency training programs, and seminars that entailed lectures, skill-based approaches,

and experiential approaches. The length of the training components encompassed 3-day workshops, 4-week training components, semester-long coursework, 9- and 14-month training programs, and no time specified. Clearly, the type of trainee, contexts for training, and length of training time were quite varied. Little attention has been given to the sample of novice level trainees studying the beginning phase of family therapy training enrolled in university based settings. Research that addressed particular types of trainees (i.e., novice level) at particular stages of training (i.e., initial stage) in specific contexts (i.e., university based programs) would enhance the research literature.

In a recent review of the outcome research on family therapy training Avis and Sprenkle (1990) suggested guidelines for future research. The following were recommendations:

> 1. A need for controlled research which creatively explores ways for controlling for relevant variables due to difficulty in using traditional designs requiring random assignment. . . . Tucker and Pinsof's (1984) Hi-Low distinction, as method for controlling for therapist experience level, was cited as an example of this.
> 2. Replication of existing research with greater specification and description of training programs and experiences, including goals . . . contexts, and conditions under which training occurs.
> 3. The development of more valid and reliable instruments to measure changes in trainees' skills. . . . the tension between simplicity/ usability and specificity/sensitivity was highlighted.

> 4. The evaluation of training in terms of its impact on therapeutic outcome. . . . this may be done indirectly by measuring changes in trainees on skills associated with positive outcome, or by studying therapy outcomes of trainees.
> 5. Design improvement, including specification of trainer/supervisor and trainee variables . . . adequate sample size, trainer-investigator nonequivalence.
> 6. Comparative studies which address the specificity question (i.e., what training is effective when, for whom under what conditions, and for what type of clinical situation. . . . such studies will be essential in determining the relative cost/effectiveness of training programs. (p. 262)

In keeping with these recommendations, the focus for this research was the novice-level family therapy trainee in the beginning phase of training from university-based programs. The structural/strategic school of therapy was targeted as the method of training. In addition, the influence of particular trainee characteristics were examined.

Training Model

The field of marriage and family therapy encompasses a wide range of approaches. They range from psychodynamic and experientially based approaches to structural, strategic, and behavioral orientations. Several studies (Henry, 1983; McKenzie, Atkinson, Quinn, & Heath, 1986) have found that structural and strategic models are taught most frequently in the United States. Although some training programs teach their students to utilize a variety of theoretical models and approaches, the programs begin with the structural approach because of its relative

simplicity, concreteness, and directness (Figley & Nelson, 1990). Because little empirical evidence supports any one theoretical approach, intellectual integrity mandates the presentation of a broad spectrum of theories (Sprenkle, 1988). However, Sprenkle noted that theoretical orientation is more evident in classroom instruction than in practice, citing Purdue University's leading marriage and family therapy program as a program that teaches all major approaches in theory courses but emphasizes brief, problem-centered interactional approaches in practica.

In a discussion of Purdue's curriculum, Sprenkle (1988) outlined the theoretical training sequence. Structural and strategic theories are emphasized in the initial state of the training. Because the focus of this research was on the novice level trainee in the beginning phase of training, it seemed logical to assess the impact of a structural/strategic approach to family therapy training.

Structural/Strategic Family Therapy Models

The structural and strategic approaches to family therapy practice are some of the most clearly articulated in the literature. Specific assumptions about the nature of the therapy process, precise description of techniques, and clear description of training methods distinguish these two schools from many of the other family therapy training models. Due to many commonalities in these assumptions,

these two models are often integrated as a structural/ strategic theory of practice. In the following sections the theoretical assumptions, major therapeutic techniques, and major goals of these two approaches are described.

Structural family therapy model. Viewing the family as an organizational system, structural therapists conceptualize the family as do other systemic approaches (i.e., as a system in evolution that constantly regulates its own functioning). However, they feature a distinctive focus on concepts that describe spatial configurations; (i.e., closeness/distance, inclusion/exclusion, fluid/rigid boundaries, and hierarchial arrangements). The key notion of complementarity is used by the structuralist to denote not an escalation of differences (Bateson, 1972) but a fit among matching parts of a whole.

From a structuralist point of view, symptomatic behavior is a part of a dysfunctional organization (e.g., an adolescent's anorexia is viewed as related to a mutual invasion of the patient's and parents' territories). Structural configurations are deemed functional or not according to how well or how badly they serve the developmental needs of the family and its members. In a dysfunctional family, development is replaced by inertia. Such a family cannot solve its problems and continue to grow because it is stuck in a rigid arrangement. Unlike other systemic approaches that focus on the function of the

symptom the structuralist focuses on the organizational flaw (i.e., the couple's avoidance of conflicts crippling their parenting of son) (Colapinto, 1988).

The dimensions of transactions most often identified in structural family therapy are boundary, alignment, and power. Each transaction contains all three of these structural dimensions. Minuchin (1974) stated, "The boundaries of subsystems are the rules defining who participates and how" (p. 53). Alignment refers to "the joining or opposition of one member of a system to another in carrying out an operation" (Haley, 1976, p. 109). This dimension includes, but is not limited to, the concepts of coalition and alliance. Coalition is defined as "a process of joint action against a third person (in contrast to an "alliance" where two people might share a common interest not shared by a third person)" (p. 109). Finally, power, also described as force, has been defined as "the relative influence of each (family) member on the outcome of an activity" (Aponte, 1976, p. 434).

Commonly described structural therapy techniques/ interventions include joining the system, boundary making, enactment, tracking sequences, reframing (or relabeling), escalating stress, creating a crisis/intensifying, symptom recomposition (add or subtract systems) (Minuchin, 1974; Minuchin & Fishman, 1981). Change is assumed to occur when dysfunctional, repetitive patterns are interrupted.

Altering clients' perceptions, expanding their world views, or reframing their behavior can lead to change in therapy. Structural goals include reorganization of the family structure and the lessening of rules/roles dictated by narrow bonds of transactions (i.e., increased flexibility in both families and their members). According to structuralists, although the presenting problem should be solved, it is done so through structural reorganization, a process allowing relevant and essential tasks within family life to be mastered more effectively.

Strategic family therapy model. The term strategic family therapy has been applied to many different approaches. Prominent figures associated with this approach include Milton Erickson, Jay Haley, Cloe Madanes, the Mental Research Institute (MRI) group (including John Weakland, Paul Watzlawick, Richard Fisch, Steve de Shazer, Arthur Bodin, and Carlos Sluzki), Gerald Zuk, Lynn Hoffman, Mara Palazzoli-Selvini, Peggy Papp, and Karl Tomm.

Generally speaking, strategic approaches to family therapy fall under what Madanes and Haley (1977) have termed the "communication" therapies. Haley (1972) defined strategic therapy as a therapy in which the clinician initiates what happens during treatment and designs a particular approach for each problem. Strategic therapists take responsibility for directly influencing people. They are not as concerned about family therapy as they are with

the theory and means for change. Strategic therapists believe that insight is not necessary to bring about change in the presenting problem. A developmental life cycle perspective is utilized. They highlight issues of circularity, sequences of interaction, behavior as communication in a relationship, and therapeutic issues as a part of theoretical assumptions.

Therapeutic techniques/intervention used by strategists include obtaining an identifiable problem, relabeling/reframing, and using the client's language and position. Strategic therapists favor going with the resistance and avoiding confrontation versus creating a crisis. They endorse direct methods of dealing with the client, however, they also endorse indirect methods (i.e., the use of paradox and metaphor, such as prescribing symptoms, restraint from change, positioning, etc.). Giving directives is an important skill in strategic therapy. Homework assignments, tasks, the use of rituals, and the use of outside teams, consultants, and supervisors are common.

Change is assumed to occur through the interruption of dysfunctional, repetitive patterns. By altering the clients' perceptions, expanding their world view, reframing/relabeling behavior, and putting a problem in a solvable form, the therapist helps produce second order change. Not only is insight not necessary but if change

occurs without the client knowing how or why that is considered sufficient (and often preferable to insight). Thus, the therapist's relationship is not endorsed as in structural family therapy. The major goal of strategic therapy is to change the presenting problem. The therapist's goal is to break the immediate and redundant behavior sequence that maintains symptoms and resolved problems quickly and efficiently, thus producing concrete behavioral change in the presenting problem. Altering the client's solution patterns or second order change is a major goal of strategic therapists.

Different approaches to strategic therapy emphasize different aspects. The Haley/Madanes approach to strategic therapy places emphasis on symptoms as metaphors, the use of ordeals, and the use of pretending. Symptoms are seen as arising from dysfunctional hierarchies. Whereas the Milan/Ackerman approach places emphasis on circularity and the inextricable nature of symptoms and systems. The MRI approach endorses a more general approach to strategic therapy.

Similarities and differences. Many similarities and differences exist in structural and strategic schools of therapy. Many summaries concerning these comparative/ contrasting views exist in the literature. In a recent project, Stone-Fish and Piercy (1987) conducted a Delphi study to examine the theory and practice of structural and

strategic family therapy. A panel of experts representing each school of therapy was identified and asked to identify the basic tenets of their schools of thought and reach a consensus by means of a Delphi procedure. Profiles were developed and similarities and differences regarding each school were identified. The structural and strategic panelists agreed that both approaches are similar in terms of (a) focusing on the present; (b) being change, rather than insight, oriented; (c) viewing problems in their relationships context; (d) giving directives; (e) assigning tasks; (f) being interactional or contextually oriented; and (g) being goal directed and concerned with therapy outcome. In addition, both schools agreed that change occurs by the interruption of dysfunctional sequences, thus producing a change in behavior and a change in perception.

However, the panelists felt that the approaches differed in theoretical emphasis. Although structural therapists emphasize family structure, strategic therapists do not. Although both schools use direct techniques to intervene in family therapy, strategic therapists tend to use indirect ones much more than do structural therapists. In addition, they noted that the goals of therapy differed across the two schools. Strategic therapists aim to solve the presenting problem although structuralists focus on reconstructing the family. Thus,

> Structuralists see the symptom as one manifestation of underlying family pathology and

> therefore logically try to reorganize the family structure. In contrast, strategic therapists take the symptom at face value, . . . and attempt to identify those interactional patterns which maintain the problem. (Stone-Fish & Piercy, 1987, p. 124)

Although integrated approaches of structural and strategic family therapy exist, it may be important in the teaching and training of family therapy practitioners to expose them to the subtle and not so subtle distinctions between the two schools. There are different ways to approach this (e.g., by tracking and supervising beginning students in one approach or the other initially or by emphasizing distinctions throughout the training process). Many therapists describe their work as a combination or as a sequence of both strategic and structural principles. Obviously this is not coincidental, as Haley was instrumental in the development of the structural school.

Structural and Strategic Models of Family Therapy Training

There tends to be an isomorphic relationship between the way therapy is constructed and training structured in the family therapy field. Literature on the training models and methods of the structural and the strategic family therapies display this consistency.

Structural family therapy training. An example of structural training is the training program of the Philadelphia Child Guidance Clinic that incorporates the tenets used in the practice of structural family therapy of observation and active restructuring of behaviors through

live supervision (Montalvo, 1973). There is an early emphasis on learning techniques in the teaching of structural family therapy in reaction to the limitations of traditional psychotherapy training with its deductive sequence from theoretical constructs to specific interventions.

> The availability of live and videotaped supervision exposed huge discrepancies that existed between the apparent understanding of concepts and the actual behavior of the therapist in the session. Thus, the idea evolved of teaching the students "the steps of the dance . . . without burdening them with loads of theory that would slow them down at moments of therapeutic immediacy." It was hoped that theoretical integration would emerge spontaneously. (Colapinto, 1988, p. 20)

With experience, the training approach has been modified for it became apparent that spontaneous theoretical integration was the exception rather than the rule using these methods. Thus the emphasis shifted to developing conceptual understanding of the model and the practical operations in the therapy room simultaneously with an integrated paradigm. A mere balance of theory and practice was considered not enough. The integration of theory and practice was necessary, a feat the structural trainer believed could occur only in the arena of supervised clinical work. "The best opportunity for the supervisor to facilitate is immediately before or during the therapeutic encounter with a family--when the therapist

is at the highest point of motivation and alertness" (Colapinto, 1988, p. 21).

A typical example of a structural training program is the Philadelphia Child Guidance Clinic's structural family therapy program which offers internships, various clinical practice, extern program, supervisory groups, evening courses, workshops, and conferences. More specifically, the extern program component is aimed at master's level trainees who are employed in an agency setting where they are seeing at least five families. Typically this particular trainee is already acquainted with the concepts of structural therapy through readings, workshops, or edited videotapes.

Colapinto (1988) has described the extern program. To summarize, the training program begins with a 3-day seminar intended to set common ground for the training process. The rest of the program revolves around direct supervision of the trainees' work with families. Clinical work is conceptualized as the arena where an integration of theory and practice can best occur. Each trainee conducts one or two sessions per day under live supervision and receives an additional half hour of videotape supervision for each hour of therapy.

The unit of training is a cycle that includes a pre-session of discussion, live supervision, post-session review, and videotape review. The integration of theory

and practice follows a pattern of alternation; the trainee works with a family, receives corrective feedback from the supervisor, returns to the family, and receives more feedback. Generic concepts such as joining, unbalancing, or enacting, are intertwined with the discussion of specific clinical situations throughout the stages of the training cycle. The integrative approach is complemented with readings assigned in accordance with each trainees' needs, videotaped sessions of experienced clinicians that the supervisor discusses to illustrate specific points, and monthly 1-day seminars where all students and supervisors meet to talk among themselves and with guest presenters. The extern program is representative of the way structuralists approach training.

Strategic family therapy training. Many models of therapy are considered to be strategic (i.e., Haley/Madanes approach, the Milan approach, and the MRI approach). For purposes of this paper the Haley/Madanes approach is discussed. It is assumed that training a strategic family therapist involves the design of a specific and individualized plan by the supervisor. The plan followed may be shared with the therapist or may be indirect and not shared. By this definition one can see the isomorphic nature between therapy and training.

Mazza (1988) described the administrative context of training at the Family Therapy Institute as follows:

> Strategic therapists are generally trained live." A small group of therapists meet to observe each other and discuss their work. Therapists who are observing may make comments or ask questions of the supervisor, but may not instruct or advise the therapist in any way. A clear hierarchy is established in which the supervisor is responsible for simultaneously training therapists and solving clients' problems. It is assumed that a therapist who brings certain live experiences to the therapy (e.g., raising a family) will be more successful than an inexperienced therapist.
>
> Families are protected from the inexperienced therapist by live supervision, and sometimes report that they look forward to knowing that more than one therapist is working on their problem. Each therapist is assigned a supervisor who discusses the intake and plans the initial phone call with the therapist. The therapist calls, sets the appointment, and arranges for the relevant family members to attend the first session. (p. 93)

The model of Haley (1976) and Madanes (1981, 1984) is one in which therapy is expected to be brief, problem focused, with planned sessions, and an active therapist is used. The goal of training is to prepare therapists to work in a variety of settings not be dependent on a team behind a one way mirror. Therapists have the opportunity to treat a wide range of clients (e.g., acute and chronic problems, poverty-level and upper class families, etc.).

Therapists are trained in a directive, learn by doing approach. Although therapists are taught specific technical skills, the training emphasizes the development of a conceptual framework. This framework provides a method of thinking rather than a method of therapy. This framework, or method of thinking, is individually crafted

to make the best use of the therapist's skills. Learning to clearly deliver directives and increase one's range of interventions are individually designed for a particular therapist in the context of treating a particular client. Thus the therapist's strengths and experiences are built upon. Depending upon the particular therapist, assignments, tasks, readings, etc. are given. Both direct and indirect (e.g., prescribe the behavior restraint from change, etc.) techniques are used in teaching. By the end of the first year of training a therapist should be able to make structural changes in the family and understand a rationale and consequence for each intervention. By the end of the second year, a therapist is expected to be able to generate a number of strategies to solve a specific problem.

Summary. In summary, there is a great deal of similarity in these two training models. Structural family therapy training emphasizes both the conceptual model and the practical operation of it in the therapy room. Live supervision is an integral part of the training with a learn by doing approach. Structuralists emphasize particular interventions and techniques (e.g., joining, unbalancing, etc.) that are more direct, focus on changing the present interactional sequence, and target the organization of the family. The current structuralist view

is that theory and technique (understanding and behavior) can and should occur spontaneously.

Strategic therapists believe that the clients' understanding of their problems follow changes in their behavior. Similarly, strategic family therapy trainers focus on changing trainees' behavior with their client families rather than by giving trainees a broad understanding of what they are to do through extensive lectures on theory. Thus, they assume that learning a new approach to treatment, both conceptually and technically, comes about by doing that treatment (Fisch, 1988). Clearly methods of training at structural/strategic family therapy training institutes are directed towards post-degree therapists. Live supervision is the cornerstone of the training with knowledge of theoretical concepts considered a given. This study focused on novice level trainees in their beginning phase of training. Preliminary phases of training emphasized theoretical concepts, a conceptual shift towards systemic thinking, and development of assessment skills.

University-Based Training in Family Therapy

The university-based context clearly differs from the previously discussed institute settings. Training is operationalized in different ways depending on whether the goal of training is to expose students to a family approach or to prepare clinicians to work with families, so the

context in which training occurs also influences the processes and outcomes of training and supervision (Haley, 1975; Liddle, 1978). Training that occurs within settings that define family therapy as a profession (e.g., family therapy institutes) differs from training that takes place within a professional discipline, such as psychology, social work, or counselor education.

Sprenkle (1988) discussed issues of training and supervision in family therapy in degree granting graduate programs. Clearly context influences the training component. For example, the training site's financial stability, means of support, stage of development, physical facilities, embeddedness or lack thereof in the community, and competing ideologies (i.e., intrapsychic versus systemic thinking) influence the nature of training.

Many accredited degree granting programs cite theoretical diversity as the hallmark of their programs. This decision is likely based on the lack of empirical research supporting any one theory, thus the presentation of a broad spectrum of theories. Nonetheless, this approach stands in contrast to the argument advanced by Liddle (1982) that it is premature to integrate theories in the field that would result in an eclectism that will not advance the field. Interestingly, Sprenkle (1988) noted that the theoretical diversity is more evident in classroom instruction than in practice. He cited Purdue University's

program as an example in which all major approaches are taught in theory courses, whereas the practice emphasizes brief, problem-centered interactional approaches.

Another interesting notion is that academic training in theory and research is the emphasis of degree granting programs. In the literature, training and supervision terms are often used synonymously, whereas academic family therapy educators insist that supervision is a subset of training, and that the latter requires mastery of the body of academic knowledge that requires years of intensive study (Sprenkle, 1988).

Issues such as these, in addition to accreditation, licensure, and third party payments by insurance companies certainly influence the development of marriage and family therapy training in the university setting. Training in the university setting is influenced by context and subsequently differs from training offered by free standing institutes.

Training Model Used in this Study

Although the terms "training," "supervision," and "consultation" are widely used in the literature, they are seldom defined and differentiated clearly. Training refers to the domain of education of professionals (Piercy & Sprenkle, 1986). It refers to the broad, comprehensive tracking of family therapy theories and techniques (such as seminars, workshops, courses, and programs) that either

precede or occur alongside the development of a trainee's clinical skills through supervised clinical practice (Saba & Liddle, 1986). Trainees are concerned with a more general transmission of conceptual and clinical knowledge.

Supervision refers to a continuous relationship, in a real world work setting, that focuses on the specific development of a therapist's skills as he or she gains practical experience in treating client families (Saba & Liddle, 1986). Focused attention on specific cases, therefore, is the hallmark of supervision.

Consultation differs from supervision in that it is a short-term, symmetrical, peer-like relationship between a therapist and an invited expert. The consultant's power is derived from his or her expertise and skill. There is no formal stake in evaluating the therapist's progress in learning or job performance (Nielson & Kaslow, 1980) as might occur in some training and supervision contexts.

This study was focused on the training of beginning family therapists in university-based introductory family therapy seminars/courses. Thus, the emphasis was placed upon exposing students to a family therapy approach that emphasized a combination on structural and strategic models of therapy. Christensen, Brown, Rickert, and Turner (1989) have summarized some general assumptions that underlie graduate level curriculum as follow:

> (a) practical solutions to problems require an integration of various theoretical schools with an

> emphasis on the development of assessment skills (Kaslow, 1987); (b) students must learn to work systemically with clients in environments where a systems approach does not exist; (c) training should consist of a combination of didactic and experiential coursework and mastery at this level should be demonstrated through more than cognitive recall; and (d) students at this level of training need to primarily master engagement and problem identification skills. (p. 84)

Goals and objectives for the sequence of training of interest in this study were based on these assumptions. Coursework that focused on theoretical concepts from major theories, and in particular structural and strategic models, with an emphasis on assessment and treatment planning were targeted as the instructional component for this research. Christensen et al. (1989) summarized courses objectives that are typical of this stage of training. These included

> (a) informational levels such as description of basic systems concepts and then history, a description of family assessment criteria (i.e., structural boundaries, hierarchy, strengths . . .), and a description of pre-interview skills; (b) perceptual levels such as the identification of basic systems concepts and elements of family structure, recognition of basic stages of an assessment/consultation interview from a videotaped interview, ability to write a concise summary of a family assessment and referral plan; and (c) application/demonstration levels such as mapping a family (video or simulative form) from a developmental, structural, and sequence view, conducting an assessment interview with a simulated family. (p. 86)

Typical evaluation activities included written exams, analysis of videotapes and simulations, brief assessment exercise, role-playing, and major paper requirements.

In summary, the segment of training of interest in this study was based on the aforementioned assumptions, goals, and objectives which have been commonly used at the initial stage of family therapy training. Clearly this method of instruction emphasizes a skill development approach which has been commonly described in the training research literature. The outcome variables of interest were changes in family therapy conceptual, perceptual, and observational skills. These changes in skills were used to evaluate this component of the training. The instrument used for evaluation of the outcome variables, the FTAE was considered an appropriate choice for this task based on previously cited research. Breunlin et al. (1983) developed this instrument to measure conceptual, perceptual, and observational skills specific to the structural and strategic schools of therapy.

Research on Therapy Trainee Characteristics

Gurman and Kniskern (1981) also recommended that family therapy training research be conducted to evaluate the impact of factors that may not be specific to any given school but may be pertinent across schools. For example, are there relatively enduring personality factors (e.g., psychological mindedness, tendency toward convergent rather than divergent thinking) that predict trainee's success regardless of the "school" of training? Research addressing these training issues that is specific to given

schools of therapy and also relevant across various schools has been the direction recommended. In an attempt to address this "specificity question" Breunlin et al. (1989) designed a research study to evaluate the effect of three of these variables on the acquisition of family therapy skills. The three variables were (a) aspects of the trainee's personal background, (b) trainee's prior training and/or clinical practice experience, and (c) components of the training experience itself. Data regarding these three sets of variables were gathered by questionnaire. The acquisition of family therapy skills was measured by the Family Therapy Assessment (FTAE) (Breunlin et al., 1983) at pretesting and posttesting. Ninety-six subjects drawn from seven training programs participated in the study. The subjects ranged in experience from little prior clinical experience to those with considerable experience. Contexts for training included university settings, agency inservice training programs, and an institute training program. All programs included some teaching of the structural/strategic model. More specifically (a) conjugal family experience, (b) prior family therapy experience and prior individual therapy experience, and (c) severity of cases and percentage of cases being seen in individual therapy were examined.

Results indicated that conjugal family experience significantly predicted family therapy learning and

specifically the therapeutic skill level. In contrast, prior experience in family therapy did not influence change in either the FTAE total or subscores perhaps due to a ceiling effect or to higher pretest scores. Previous experience in individual therapy did predict changes, however, in family therapy learning, specifically conceptual skill. This finding was of surprising interest because, in the past, family therapy educators and trainers (e.g., Haley, 1981) have predicted that individual training would be counterproductive to the theory and practice of family therapy. In addition, the program variables of severity of cases and percentage of individual cases also had predictive significance.

By their own admission, Breunlin et al. (1989) stated that these results can only be taken as suggestive and needing replication (due to methodological problems and missing data). However, they reported the results because of the scarcity of studies in family therapy training. More importantly, these researchers suggested that "trainee characteristics matter a great deal even after selection for training; accounting for 18% (as a population estimate) of the total FTAE score improvement, or better, for about half of the reliable variance in the total change score" (Breunlin et al., 1989, p. 11).

In summary, Breunlin et al. (1989) illuminated an approach that goes beyond the model of pretest-posttest

studies and begins to look at how personal characteristics of the trainee effect acquisition of skills in family therapy training. Five other studies have been conducted in which the researchers have attempted to control for important trainee variables such as gender, experience level, and previous training. In previous literature, Tomm and Leahy (1980) controlled statistically for gender, marital status, and previous work experience, and Tucker and Pinsof (1984) and Zaken-Greenberg and Neimeyer (1986) controlled for trainee experience. This researcher sought to extend this type of research by examining the effect of particular characteristics of the marriage and family therapy trainee on the acquisition of skills.

Therapist Variables in Individual Counseling Training

It is not surprising that the specificity question in the field of family therapy has not been addressed, as the parallel question with regard to general psychotherapy training, itself, has been difficult to answer (Paul, 1967). Much of the training research in marriage and family therapy focused on skill acquisition as originally proposed by Cleghorn and Levine (1973). Similarly, an emphasis on the skills training approach has been a common component of graduate level counseling programs (e.g., Carkhuff, 1969; Egan, 1982; Ivey, 1978; Traux & Carkhuff, 1967). In 1977, Mahon and Altmann expressed concern that counseling skills training has been applied in a uniform

manner that ignores both learner and learning process variables that could affect training outcome and counseling effectiveness.

Therapist factors that can affect the learning of family therapy skills, and even more importantly the outcome of psychotherapy, are complex. In a review of the literature on therapist variables in psychotherapy process and outcome research, Beutler, Crago, and Arizmendi (1986) discussed the complexity of conducting research such as this. They emphasized the need to continue research directed towards understanding the complex interactions between therapist, intervention, client, and the nature of outcome.

Some research has emerged in the general body of individual counseling and psychotherapy training literature that studied the effect of trainee variables on the acquisition of therapy skills. Mahon and Altmann (1977) suggested that learner perceptions and attitudes may affect the control, the intentionality, or the flexibility of skill used by the trainee, which could in turn determine the selection and production of discrete skills during counseling. Hirsch and Stone (1982), in a study examining attitudes and behaviors in counseling skills development, proposed that trainee attitudes have a mediating influence on the effectiveness with which counseling skills are employed.

Attitudes of counselors have been found to influence perceptual and behavioral flexibility. Wampold, Cass, and Atkinson (1981) found that stereotyping interferes with the counselor's processing of information about ethnic minorities. In another study, stereotyping of homosexual individuals versus heterosexual individuals was also found to interfere with the counselor's processing of information (Cass, Brady, & Ponterotto, 1983).

Recently some studies have examined the impact of trainee variables on the acquisition of therapy skills. Fong and Borders (1985), Fong, Borders, and Neimeyer (1986), and Neimeyer and Fong (1983) explored the relationship between self-disclosure flexibility and counselor effectiveness during a counseling training course in which 53 students were enrolled. Results revealed that more flexible disclosures initially produced more effective counseling responses than did less flexible disclosures, but that these differences were attenuated over the course of training.

Fong and Borders (1985), using the Bem Sex Role Inventory, reported that counseling students' sex role orientation had an effect on counseling skills performance. In particular, masculine oriented trainees were rated as less effective and undifferentiated than the other sex role orientation groups. However the androgynous orientation

trainees were less effective than either the feminine or the undifferentiated orientations.

In a more recent study, Fong, Borders, and Neimeyer (1986) examined the impact of sex role orientation and self-disclosure flexibility of 44 counseling students on their ability to demonstrate counseling skills and their overall counseling response effectiveness during and after counseling skills training. Using factorial analyses, sex role orientation and level of self-disclosure flexibility accounted for approximately 30% of the variance in quality of counseling skills. These findings lend support to the importance of trainee perceptual, cognitive, and behavioral flexibility in the acquisition and use of counseling skills. The authors challenged the assumption that instructional input can account for most of the variance in trainee skill performance and suggested that the trainees' perceptual, cognitive, and behavioral flexibility for developing counseling skill proficiency may be an important source of variation. They recommended using other indicators of flexibility in research studies to describe more clearly how these variables mediate the learning and use of counseling skills.

It has been suggested that compatibility between the cognitive styles of members of a relationship would affect both the process and outcome of a relationship (Handley, 1982). Many studies of interpersonal compatibility have

used the Myers-Briggs Type Indicator (MBTI) (Handley, 1982; Yura, 1972; Wyse, 1975). For example, Handley (1982) examined the relationship between the similarity of cognitive styles of supervisors and counselors in training and supervision process and outcome measures. As previously noted, he found that intuitively oriented counselors in training received higher supervisor ratings than did other counseling students. Similarity between supervisors and counselors in training on the MBTI S-N scale was reported to be related to practicum student's satisfaction with supervision. Handley's findings supported the hypothesis that similarity of cognitive styles improves accuracy of communication in the supervisory relationship. However, these findings are preliminary.

As previously noted, Carey and Williams (1986) compared 18 practicum supervisors and 46 counselors in training in terms of dominant counseling style and related cognitive style of counselors in training to the supervision process and outcome measures. In contrast to findings of previous researchers, a strong relationship between the cognitive style of counselors in training and supervision process and outcome measures was not detected in this study. Perhaps cognitive styles change during counseling training depending on the developmental stage of the trainee or the general content of the tasks at hand.

Clearly this research supports the concern voiced by Mahon and Altmann (1977) and Hirsch and Stone (1982) that counseling skills training should not be uniformly taught to all counselor trainees. In addition, it supports the need for further research on the impact of personal trainee variables on the learning process. As previously mentioned in parallel literature, Gurman and Kniskern (1988) suggested that marriage and family training researchers are beginning to grapple with the specificity question (i.e., what types of training experiences, with which types of trainees produce effective therapists within a particular model of therapy).

As discussed previously, Breunlin et al. (1989) reported the results of a study designed to examine the effect of trainee variables on the acquisition of family therapy skills. Variables in their study concerned conjugal family experience, prior training in individual and family therapy, and program variables (e.g. severity of cases). They concluded from their research that trainee characteristics matter a great deal even after selection for training, accounting for 18% of the variance of the total score improvement of trainees.

Of interest to this research effort is the prior training variable as a factor for acquisition of skills. In the general body of psychotherapy literature, Fielder (1950) found that therapists, regardless of orientation,

became more similar as their experience increases. More recent literature revealed that experience facilitated some therapy processes such as therapists' empathy (Auerbach & Johnson, 1977) and patient satisfaction (Beutler et al., 1986). Gurman and Kniskern (1978) cited therapist experience level as a factor that influences the outcome of family therapy and suggested that studies include this variable.

Beutler et al. (1986) suggested that investigations should distinguish between amount (e.g., number of years) and type (e.g., professional discipline) of training. Thus experience level should be considered independent of formal training. This researcher examined the impact of the trainee's prior training (in individual counseling and marriage and family therapy) and prior work experience (in individual counseling and marriage and family therapy) on the acquisition of therapy skills.

In addition to studying the impact of prior training and work experience on therapy, this researcher also examined the impact of the learning style of the trainee on the acquisition of family therapy skills.

Learning Style

An examination of instructional theories (e.g., Bruner, 1968; Gagne & Briggs, 1979) suggested that additional variables warranted consideration in attempting to account for individual differences in learner skill

acquisition and in developing comprehensive approaches to skill training. Clearly characteristics of both the supervisor (teacher) and supervisee (learner) affect the interaction that occurs between them. Hart (1982) suggested that supervisee aspects to be examined during the learning process include expectations (of supervisee and supervisor), levels of training and experience, patterns of interpersonal behavior, and learning style. In this context learning refers to the speed and efficiency with which supervises can acquire various types of information. For example, some supervisees are able to learn best from principles that are discussed and demonstrated whereas others learn best by critiques of their performance with clients. Hart (1982) suggested that learning style, like other interpersonal patterns, is an important consideration in the supervisory and teaching/learning process. He recommended conducting research that includes the consideration of learning style as an important variable affecting the supervision and teaching/learning process.

Hart (1982) encouraged the clinical supervisor to select techniques that are appropriate for the supervisee with particular intellectual characteristics. For example, Berengarten (1957) described major learning patterns of social work students as either (a) doing, (b) experiential-empathic, or (c) intellectual empathic. The "doer" learns best from specific directions regarding the task. The

experiential-empathic learner tries out hunches and relies on results of intuitively proceeding with tasks that seem appropriate. The intellectual-empathic learner relies on deliberate plans that are carefully thought out before any action is taken. In another study Rosenthal (1977) examined the effects of learning style and conceptual level of supervises on the learning of clinical skills. His results indicated that the effectiveness of the method of teaching a clinical skill (confrontation) was dependent upon the conceptual level (high or low) of the supervisee. Clearly, considering trainee learning style when examining trainee skill acquisition is an important area.

Research on the outcomes of live supervision has begun to differentiate learning styles and preferences and has defined some predictable trainee responses from therapists who have undergone a live supervision experience (Liddle, Davidson, & Barrett, 1988). For example, Liddle et al. (1988) assessed, through structured interview format, 85 trainees from a variety of training contexts in which live supervision was a component. The results provided an initial picture of the variables that might warrant further description and experimental inquiry. More specifically, they noted that the preference for active participation in the formulation of therapeutic plans during live supervision was expressed by the majority of trainees. However, this preference was more pronounced with trainees

who saw themselves as having an active learning style than those having a more passive style of learning. The conclusions drawn by the authors were that personal involvement in the learning process was seen as crucial to trainee success in supervision and that passive learning styles were viewed as less beneficial than active ones.

Clearly, the variable of learning style may have a significant impact on the acquisition of therapy skills. The trainee's mode of observing, taking in data about the world, organizing it, and acting upon it in the realm of individual and family therapy training may influence the learning of therapy skills. A number of different theories and models of cognitive style/learning style have been proposed. A well-known example is the Myers Briggs Type Indicator which is based on Jung's theory of psychological types. Many models such as this have been used to sort individuals into career/occupational categories as a way of applying/resolving cognitive tasks (e.g., Kolb, 1976, 1981).

Few of the learning models have been used to predict learning and performance of specific job tasks. Identifying preferred learning style and motivation patterns may be of interest, however, not only in terms of a selection factor in training but as a curriculum planning component as well. For example, the Myers-Briggs Type Indicator has been used as an indicator to provide

classroom structure, tasks, and assignment geared towards specific personality types/learning styles of students in elementary/secondary education. The implications for research that includes learning style of the trainee as a variable in the therapy learning process are many.

Variables of Interest in the Study

In the following sections, the outcome variables and the four trainee variables of interest in the study (i.e., prior training in individual counseling and marriage and family therapy, prior work experience in individual counseling and marriage and family therapy, initial knowledge of family therapy, and learning style) are discussed.

Outcome Variables

The outcome variables examined in this study are the change in observational (perceptual), conceptual, and therapeutic (executive) skills of the family therapy trainee from pretesting to posttesting. These skills were originally defined by Cleghorn and Levine (1973) and have been subsequently used in describing learning objectives (e.g., Falicov et al., 1981; Tomm & Wright, 1979) for marriage and family therapy training in most of the published accounts.

Observational skills are those required to perceive and accurately describe behavioral data within a session. Conceptual skills are those inherent in a theoretical

understanding of a model. Therapeutic skills are those necessary to execute interventions skillfully within the session according to one's model of therapy, and in this case, the structural/strategic model of family therapy. Breunlin et al. (1983) have developed an instrument to evaluate change in terms of observational, conceptual, and therapeutic skills as previously defined. This is the measure used in the study to assess change in these skills.

Observational (perceptual), conceptual, and executive (technical) skills have been previously discussed in the review of the training literature. These three interrelated sets of skills are commonly used in the training research.

Family Therapist Assessment Exercise

Breunlin et al. (1983) described the Family Therapist Assessment Exercise (FTAE) as an instrument-in-process designed to evaluate family therapists and the effectiveness of family therapy training. The instrument is based on (and assesses competence in) the structural-strategic model of family therapy which integrates structural family therapy as espoused by Minuchin and his colleagues (Minuchin, 1974; Minuchin & Fishman, 1981; Minuchin, Rosman, & Baker, 1978); problem-solving and strategic therapy of Haley and Madanes (Haley, 1976; Haley, 1980; Madanes, 1981); and the brief therapy of the MRI group (Watzlawick, Weakland, & Fisch, 1974) and the

Ackerman Brief Therapy Project (Hoffman, 1981; Papp, 1980). Breunlin et al. (1983) claimed that they were, in essence, measuring therapists' ability to systemically conceptualize as

> a crucial conceptual element of this model of family therapy is the ability to think "systemically," that is to view a family member's actions as one part of a redundant family dance, rather than being caused by another member's actions or be intrapsychic events or personality traits. (p. 43)

The instrument consists of a videotape of a first session with an enacted family. The script on the videotape is of an actual first session (edited down to 30 minutes) so that it can replicate the type of stimulus data a therapist actually encounters. The use of the videotape provides a standardized stimulus for the written component of the instrument. A wide range of interventions are illustrated and family dynamics of moderate complexity are depicted. Some modifications were introduced in order to highlight important conceptual material and include therapist behaviors, some of which would be considered mistakes. The final tape was filmed using professional actors and sophisticated audio/visual reproduction, providing transitions between the edited segments. Four family therapists reviewed the manual and tape and determined that it was representative of the scope of knowledge represented by the structural-strategic model (hence possessing respectable content validity).

They have designed the instrument to assess three inter-related sets of skills: observational, conceptual, and therapeutic skills (Falicov et al., 1981). These are virtually the same as Cleghorn and Levine's (1973) perceptual, conceptual, and executive skills. Observational skills are those required to perceive and accurately describe behavioral data within a session. Conceptual skills are those inherent in a theoretical understanding of a model. Therapeutic skills are those necessary to execute interventions skillfully within the session according to one's model of therapy, in this case the structural-strategic model of family therapy.

The instrument is intended to measure therapists' competence in these three sets of skills as applicable within the clinical situation depicted on the videotape. Observational skills are measured by how perceptive the respondent is to behavioral data and sequences; conceptual skills are measured by whether the respondent chooses the "correct" (per theoretical orientation) concept that corresponds to that segment of behavioral data. Because the respondent is observing another conduct therapy on a videotape, it is more difficult to assess the respondent's actual therapeutic skills. But the test asks the respondent to identify and evaluate the therapist's behaviors on the videotape as well as to choose which of the multiple choice responses he or she would most likely

choose as a therapeutic intervention in response to the prior sequence portrayed on the tape. These, of course, may not predict whether the respondent would actually act this way if in a similar clinical situation.

Development of the Instrument

To date, there have been five progressively refined versions of the test based on the researchers' pilot studies. The first version used broad, open-ended questions to explore how therapists would respond to the tape. A subjective comparison of pretraining and posttraining test responses from 12 clinical externs in family therapy revealed a substantial improvement in complexity of answers with increased application of training knowledge to the tape.

In constructing the second version, the answers that were obtained using the initial, open-ended version were generated for each item: one preferred and three alternatives, each of which were weighted. It was hoped that the weighing would render a more accurate indication of progress in therapist competency from pretesting to posttesting. Questions were included only if there was unanimous agreement among the researchers on the correct answers. The second form included 20 questions--7 observational, 11 conceptual, and 2 therapeutic. This version was then shown to two other family therapists who each concurred with the right answers.

The second version was piloted on five groups of pediatric residents (n=13) and three groups of third-year medical students (n=9). A comparison of pretraining and posttraining scores indicated significant improvement ($p. < .01$) suggesting that both the training was effective and that the instrument sensitively measured the training impact.

The third version consisted of 13 multiple-choice conceptual questions, 5 observational questions (in which the respondent must recall an interactional sequence using a fill-in-the-blank format), 8 multiple-choice therapeutic questions (mostly critiquing the therapist's behavior on tape), and 7 therapeutic questions that require the respondent to write a therapeutic intervention.

This version was reviewed and then taken by two other family therapy trainers to verify concurrence on the multiple-choice answers. There seemed to be greater difficulty reaching agreement among the experts regarding the therapeutic items. Apparently, it was easier to agree about what the family is doing and what needs to happen than when and how this should best occur. For this reason, it seemed that the third version of the instrument was a more valid measure of observational and conceptual skills than therapeutic skills.

This third version has been pretested on three pilot groups of differing expertise levels (n=13, n=8, n=11).

The correlation between experience level and average score is as would be expected and suggested that the test level of difficulty has avoided the previous problem of a ceiling effect.

In the fourth version of the FTAE, because of the ominous task of scoring open-ended items, Breunlin and colleagues opted to back track and convert the entire instrument to a multiple-choice format. They chose some of the most popular responses from the open-ended pilot runs and cast them as potential choices within the multiple-choice format. In contrast to earlier versions of the instrument, however, the "correct" response was embedded with equally reasonable alternatives and thereby not obvious to the respondent.

The fifth refinement of the Family Therapy Assessment Exercise (FTAE) is used in this study. This current version is a procedure in which subjects watch a simulated family therapy interview on videotape and answer the questions of a 32-item, multiple-choice format test. Of these 32 questions, 5 are observational, 11 are conceptual, and 16 are therapeutic. Although Breunlin et al. (1989) reported continued difficulty with the observational scale, several studies (Hernandez, 1985; Pulleyblank, 1985; Pulleyblank & Shapiro, 1986; West et al., 1985) provided evidence that the conceptual and therapeutic scales of the current version of the FTAE discriminate well, as does the

total score. These studies have been previously discussed in the review of the family therapy training literature.

Finally, it should be noted that throughout each version of the FTAE, Breunlin and colleagues constructed the instrument so that it maintained jargon-free terminology even though it assessed competence in the structural-strategic model. This allowed those uninitiated to family therapy to understand the alternatives and insured that the test measures more than the respondents' acquaintance with the vocabulary of the model. But, due to its reliance on the structural-strategic model, Breunlin and colleagues commented that it is theoretically possible that a highly trained clinician from a contrasting school might do very poorly on this test. However, in this study a structural/strategic model of therapy comprised the treatment component, therefore, this particular issue should not pose a problem.

Trainee Variables (Characteristics)

Much of the research done in the area of training in marriage and family therapy has been done with postgraduate level trainees in family therapy training centers and institutes. Little research has been done that targeted the novice level trainee enrolled in degree granting programs in university-based settings. The role of free-standing institutes relative to teaching family therapy in traditional institutions such as academic departments

within universities remains to be defined. This researcher targeted the beginning trainee in marriage and family who was enrolled in a university-based training experience. The variables of interest examined were the trainee's (a) prior training, (b) work experience in both individual counseling and in marriage and family therapy, (c) initial knowledge of family therapy, and (d) the learning style of the trainee.

Prior training and work experience in individual counseling/therapy and marriage and family therapy. Of interest in this study was the effect of trainee's previous training and experience in individual therapy and in marriage and family therapy on the acquisition of observational, conceptual, and therapeutic skills of family therapy. It has been commonly and perhaps intuitively presumed that prior training in individual psychotherapy interferes with the cognitive shift to systemic thinking and the learning of marriage and family therapy in general. However, Pulleyblank (1985) discussed the need to clarify what experience prior to family therapy training was relevant to the success as a family therapist. In Pulleyblank's study, a self-evaluation component was used in conjunction with other measures. She found that the more years experience prior to family therapy training that the trainees had the lower they rated themselves on observational, conceptual, and therapeutic skills of family

therapy, and particularly on the conceptual scale. Although the trainees rated themselves lower at the beginning of training, they did as well if not better than others at the end of training. This finding departs from the belief in the field of family therapy (Haley, 1981) that traditional training is useless if not counterproductive for family therapy.

In yet another study, Breunlin et al. (1989) reported that previous experience in individual therapy predicts changes in family therapy learning and in fact may have a beneficial effect on family therapy training. Thus further research is necessary. The question still remains whether family therapy is a totally new form of therapy or a treatment that requires skills in addition to traditional psychotherapy skills (such as the ability to listen and empathize which allows the family therapist to join with the family in a way that promotes family change).

As mentioned earlier, a body of research exists in the family therapy outcome literature that cites family therapist's experience level, therapy structuring skills, and relational skills as factors that influence the outcome of family therapy (Gurman & Kniskern, 1978). Experience level cannot be taught, but because high levels of experience have been correlated with positive therapeutic outcome, the behavior of experienced therapists can be indirect criterion for training success. Gurman and

Kniskern (1988) suggested addressing the question of "what types of previous training best prepares/or inhibits a trainee for training" (p. 375). This study was designed to examine both prior training in individual counseling and marriage and family therapy and prior work experience in individual counseling and marriage and family therapy. In this study level of experience was considered independent of formal training as recommended by Beutler et al. (1986). The level of initial knowledge of family therapy has also been considered independently as suggested by Breunlin et al. (1989). In addition, theoretical orientation in terms of individually oriented therapy versus family systems oriented therapy was distinguished.

Much of the available family therapy research examined post-degree clinicians in family therapy training institute contexts (Breunlin et al., 1983, 1989; Hernandez, 1985; Pulleyblank, 1985; Pulleyblank & Shapiro, 1986; Tucker & Pinsof, 1984). Only a few researchers examined novice level trainees in university-based settings (West et al., 1985; Zaken-Greenberg & Neimeyer, 1985). Clearly the latter, by definition, have less experience and less formal training.

Therefore, the approach to teaching the novice level trainee may differ greatly from the approach used for the therapist versed in individual psychotherapy. For example, Tomm and Leahey (1980), in a comparison study of three

teaching methods used to teach basic family assessment methods to first year medical students, concluded that the lecture-demonstration approach is the method of choice for teaching family assessment to these beginning medical students based on cost-effectiveness. Individual therapy may be a variable that predicts success in the learning of marriage and family therapy after selection. In addition, the unique impact of family therapy training over and above (or instead of) individual training needs further empirical support.

Prior training. In this study prior training was defined in terms of number of formal academic courses and number of supervision hours accumulated in individual counseling and in marriage and family therapy. Individual counseling/psychotherapy refers to individually oriented theory/therapy. Marriage and family therapy refers to therapy that focuses on general systems theory and thinking.

Prior work experience. In this study prior work experience was defined in terms of number of hours spent in providing direct client contact or services with cases in both individual therapy and marriage and family therapy. Individual counseling refers to individually oriented therapy; whereas marriage and family therapy refers to therapy that focuses on the marriage and family unit.

Initial knowledge of family therapy. Initial knowledge of family therapy was defined as the students knowledge of observational, perceptual, and perceptual skills as discussed by Breunlin and his associates (Breunlin et al., 1983, 1989).

Learning style. Learning style was the final variable chosen for this study. As previously mentioned, there have been some attempts made to assess the interaction between personal characteristics of the trainee and the acquisition of therapy skills. The importance of learning style as a factor in the education and training process has been discussed previously. In addition, Gurman and Kniskern (1988) specifically mentioned convergent/divergent thinking styles as a potentially important family therapy trainee variable.

It is logical to assume that learning style is an important factor and one would assume influential in the learning of marriage and family therapy skills. This study examined the "interaction" of the trainees' learning style on the acquisition of family therapy skills (observational, conceptual, and therapeutic).

West et al. (1985) reported the evaluation of a training experience in which a technique using simulated families in the training of 10 novice level therapists was used. The Family Therapy Assessment Exercise was used to measure observational, conceptual, and therapeutic skills

in a time series design with testings at three intervals. Within this study the training experience significantly increased students' total scores from the base measurement (testing 1) to the second testing and from the base measurement to the final testing time or end of the course. Further analysis revealed that

> observational and conceptual subtests scores combined to produce the significant differences from time 1 to time 3 and conceptual skills significantly increased from time 2 to time 3. The interesting aspect of these results was the order of change. Apparently a significant gain was made in conceptual skills before the gain in observational skills. (West et al., 1985, p.56)

The authors noted that this finding may have implications for the training of family therapists, and perhaps suggests that the novice level therapist requires a conceptual framework or cognitive map before being able to pay attention to small units of family interaction. It would seem that meaning must be attached to small units of behavior before the behavioral sequences can be integrated within a larger theoretical understanding of the family.

The idea of sequence in the learning of observational, conceptual, and therapeutic skills in the training of family therapists is interesting. Clearly the developmental stage (Hart, 1982) of the trainee impacts needs and expectations of training and changes over time. Novice level trainees may require different sequencing of training than post-degree clinicians studying family therapy. Learning style of the trainee could also be a

factor in designing training and, specifically, the sequencing of particular skills. For example, a trainee who exhibits an abstract versus concrete approach to learning may have more ease in learning conceptual skills. Whereas a trainee who exhibits an active approach to learning versus a reflective approach may have more ease in acquiring therapeutic skills (i.e., joining, unbalancing). Determining the trainee's learning style could also be helpful in designing training experiences that meet the needs of differing types of learners. The idea of creating training experiences that are unique to the individual and their stage of professional development is not new to the general body of supervision and training literature (Hart, 1982; Stoltenberg, 1981). Various educators advocate designing training experiences that are unique to the individual needs and goals of the trainee. Assessing the learning style of the trainee could help the trainer determine strengths and weaknesses and subsequently design learning experiences accordingly (to remediate weak areas or build on strengths).

At this time there are no reported studies in the marriage and family training literature that address learning style of the trainee. However, the concept of individual learning style and motivation patterns has been established. For example, Lawrence (1979) used the Myers-Briggs Typology which is based on Jung's psychological

types as a guide and theoretical framework to discuss instructional strategies. The individual learner's type and preferred process (e.g., sensing/intuition) was used to categorize them and suggest implications for instructional planning, developmental needs of the learner, and teaching style used.

Another theory of learning found in the learning style research literature is Kolb's Theory of Experiential Learning which is based on the works of Dewey (1938), Lewin (1951), and Piaget (1970). Using this framework several studies have been conducted concerning learning style and personality type (Margerison & Lewis, 1979), learning style and educational specialization (Hudson, 1966), learning style and professional career (Bennett, 1978; Christensen & Bugg, 1979; Kolb, 1978; Plovnick, 1974; Sims, 1980), learning style and job role (Plovnick, 1974, 1975), and learning style and adaptive competencies (Kolb, 1984). In these studies, learning styles are conceived of as a

> possibility processing structures resulting from unique individual programming of the basic but flexible structure of human learning. These possibility processing structures are best thought of as adaptive states or orientations that achieve stability through consistent patters of transactions with the world. (Kolb, 1984, p. 97)

Thus learning style is not conceived of as a "fixed" personality trait but as flexible.

The four basic learning styles based on research and clinical observation by Kolb (1976) and others are

convergent, divergent, assimilative, and accommodative styles.

The convergent learning style is demonstrated by abstract conceptualization and active experimentation learning abilities. Problem solving, decision making, and practical application of ideas are strengths of individuals reflecting a convergent learning style.

> A person with this style seems to do best in situations like conventional intelligence tests, where there is a single correct answer or solution to question or problem (Torrealba, 1972; Kolb, 1976). In this learning style, knowledge is organized in such a way that through hypothetical-deductive reasoning, it can be focused on specific problems. Liam Hudson's (1966) research on those with this style of learning (using other measures that the LSI) shows that convergent people are controlled in their expression of emotion. They prefer dealing with technical tasks and problems rather than social and interpersonal issues. (Kolb, 1984, p. 77)

The divergent learning style emphasizes concrete experience and reflective observation. Thus, the individual reflecting a divergent learning style relies on opposite strengths from an individual with the convergent learning style. Imaginative ability and awareness of meaning and values are strengths of the individual reflecting a divergent learning style.

> The primary adaptive ability of divergence is to view concrete situations from many perspectives and to organize many relationships into a meaningful "gestalt." The emphasis in this orientation is on adaptation by observation rather than action. This style is called diverger because a person of type performs better in situations that call for generation of alternative ideas and implications, such as a "brainstorming"

> idea session. Those oriented toward divergence are interested in people and tend to be imaginative and feeling-oriented. (Kolb, 1984, p. 78)

In an individual demonstrating an assimilative learning style, abstract conceptualization and reflective observation are emphasized. The greatest strength of an individual reflecting this orientation lies in inductive reasoning and the ability to create theoretical models.

> As in convergence, this orientation is less focused on people and more concerned with ideas and abstract concepts. Ideas, however, are judged less in this orientation by their practical value. Here, it is more important that the theory be logically sound and precise. (Kolb, 1984, p. 78)

The individual demonstrating an accommodative learning style emphasizes concrete experience and active experimentation. Thus, the individual reflecting this learning style relies heavily on opposite strengths from the individual reflecting an assimilative learning style. Involvement in new experiences and carrying out plans and tasks are strengths of this individual.

> This style is called accommodation because it is best suited for those situations where one must adapt oneself to changing immediate circumstances. In situations where the theory or plans do not fit the facts, those with an accommodative style will most likely discard the plan or theory. (With the opposite learning style, assimilation, one would be more likely to disregard or reexamine the facts.) People with an accommodative orientation tend to solve problems in an intuitive trial-and-error manner (Grochow, 1973), relying heavily on other people for information rather than on their own analytic ability (Stabell, 1973). Those with accommodative learning styles are at ease with people but are sometimes seen as impatient and "pushy." (Kolb, 1984, p. 78)

The Kolb Learning Styles Inventory and construct have been used in various studies concerning counseling and education. Its application in the area of counseling and supervision (Abby, Hunt, & Weiser, 1985) and in the learning process of ethical reasoning in the context of education for counselors and psychologists (Pelsma & Borgers, 1986) has been demonstrated. For example, Abby et al. (1985) proposed that counseling is a complex learning situation that may be analyzed from the standpoint of an experiential learning model. Their perspective is based on the work of David Kolb. It is proposed that the four modes of experience: Concrete Experience (CE), Reflective Observation (RO), Abstract Conceptualization (AC), and Active Experimentation (AE) must be accessible to the learner (client or student counselor) for optimum functioning. An analyses of dialogue from a therapy session and an supervision session demonstrate their point.

Pelsma and Borgers (1986) applied Kolb's theory to propose a model that explains the learning process of ethical reasoning. The learning process (Kolb, 1976) and a developmental scheme of ethical reasoning (Van Hoose, 1980) were integrated. Implications for ethics training in educational programs and ethical behavior in professional practice were discussed. For example, the value of an experience-based model lies in its focus on the how rather than the what of learning. Thus process is emphasized

versus content which is a basic tenet of many models of family therapy (e.g., structural/strategic schools of thought). Although Kolb's construct and instrument have not been used in terms of marriage and family therapy training studies to date, its application is apparent. In the next section a brief overview of the Kolb Experiential Learning Theory is presented.

Kolb's experiential theory of learning. Learning is the process whereby knowledge is created through the transformation of experience (Kolb, 1976). According to Kolb (1976) learning itself is a four stage cycle. To adapt successfully to the environment, the learner needs four different kinds of abilities: concrete experience (feeling), reflective observation (watching), abstract conceptualization (thinking), and active experimentation (doing). Kolb derived this sequential model from the work of Kurt Lewin (1951) and used it as the basis for his learning style approach. His model integrates the four methods of relating to the world into a circular representation of the learning process. Immediate concrete experience is the basis for observation and reflection. Observations are assimilated into a theory from which new implications for action are deduced. These implications or hypotheses then serve as guides for creating new experiences. Each of these processes represents a learning mode or method of acquiring new information. As a person

ages and accumulates more experience, learning modes stimulate major dimensions of personal growth. The way learning shapes the course of development can be described by the level of integrative complexity in the four learning modes--affective complexity in concrete experience results in higher-order sentiments, perceptual complexity in reflective observation results in higher-order observations, symbolic complexity in abstract conceptualization results in higher-order concepts, and behavioral complexity in active experimentation results in higher-order actions.

The model, similar in many ways to other experiential learning models (Dewey, 1938; Lewin, 1951; Piaget, 1970), suggests that learning involves a tension-filled and conflict-filled process. New knowledge, skills, or attitudes are achieved through confrontation among the four modes of experiential learning which are considered polar opposites (concrete versus abstract, reflection versus action). The learner, facing a new experience, must continually choose which set of learning abilities to use in any specific learning situation. The learner moves in varying degrees from actor to observer and from active involvement to general analytic detachment. The resolution of these conflicts produces learning and adaptation and results in a higher order functioning and development in the corresponding growth dimensions.

According to Kolb (1984), the development of each dimension proceeds from a state of "embeddedness, defensiveness, dependence, and reaction to a state of self actualization, independence, provocation, and self direction" (p. 141). This process is marked by increasing complexity and relativism in dealing with the world and one's experience, and by higher level integrations of the dialectic conflicts among the four primary learning modes. In the early stages of development, progress along one of these four dimensions can occur with relative independence from others. The child and the young adult, for example, can develop highly sophisticated symbolic proficiencies and remain naive emotionally. At the highest stages of development, however, the adaptive commitment to learning and creativity produces a strong need for integration of the four adaptive models. Development in one mode precipitates development in others. Increases in symbolic complexity, for example, refine and sharpen both perceptual and behavioral possibilities. Thus, complexity and the integration of dialectic conflicts among the adaptive modes are all the hallmarks of true creativity and growth.

The human developmental process is divided into three broad developmental stages of maturization: acquisition, specialization, and integration. By maturational stages we refer to the rough chronological ordering of ages at which developmental achievements become possible in the general

conditions of contemporary western culture. Actual developmental progress will vary depending on the individual and his or her particular cultural experience. Even though the stages of the developmental growth process are depicted in a simple form, the actual process of growth in any single life history probably proceeds through successive oscillations from one state to another. Thus a person may move from stage 2 to stage 3 in several separate subphases of integrative advances followed by consolidation or regression into specialization. This multilinear aspect differs from other learning theorist's unilinear approaches (e.g., Piaget).

Kolb drew from the intellectual origins of experiential learning in the works of John Dewey, Kurt Lewin, and Jean Piaget. The learning model of these respective theorists has laid the foundation for experiential learning. Experiential learning offers the foundation for an approach to education and learning as a life-long process that is soundly based in the intellectual traditions in social psychology, philosophy, and cognitive psychology. Contemporary applications of experiential learning theory are found in education, organizational development, management development, and adult development.

Summary

In summary, the need for research on the impact of particular marriage and family therapy trainee

characteristics is evident. This study examined the influence of personal characteristics of the trainee (i.e., previous training and work experience, knowledge of family therapy, and learning style) on the learning of marriage and family therapy. Implications for this type of research are many. Not only does this replicate and extend past research (Breunlin et al., 1989), but it adds to the body of much needed family therapy training research. Additionally, the results of this study may also have implications for designing and developing training experiences for varying populations (beginning therapists) in varying contexts (university-based programs).

CHAPTER III
METHODOLOGY

The purpose of this study was twofold. First, the levels of family therapy skill acquisition of student therapists participating in the initial stage of academic family therapy training were examined. Second, the influence of four types of trainee characteristics on the acquisition of these skills was assessed. The four types of trainee characteristics examined were (a) the extent of prior professional training in individual therapy and in family therapy, (b) the extent of prior professional work experience in individual therapy and in family therapy, (c) the initial level of family therapy knowledge, and (d) the type of learning style preferred.

In this chapter the methodology used in the study is described. The chapter includes a description of the research design, the population and sample, the sampling procedures, the instruments used, the data collection procedures, and the data analysis procedures.

Research Design

A correlational design was used in this study. Information on four types of trainee variables was used to predict family therapy skill acquisition by student

therapists enrolled in graduate-level introductory family therapy courses. Trainee variables included (a) extent of previous individual counseling training and family therapy training, (b) extent of clinical work experience in individual counseling and family therapy, (c) extent of prior knowledge of family therapy, and (d) type of learning style preferred. The criterion variables were observational, perceptual, and executive family therapy skills. These skills were measured prior to and following the completion of the initial training stage.

Trainee Variables

In this study trainee variables are defined as prior training in individual counseling and family therapy, prior work experience in individual counseling and family therapy, prior knowledge of family therapy, and type of learning style preferred by the trainee.

Previous individual counseling training and family therapy training refers to the number of graduate level courses in individual counseling and marriage and family therapy completed by the trainee and the number of supervision hours for individual counseling and family therapy reported by the trainee. Prior training was assessed from responses to items found in the Therapy Experience Inventory.

Previous work experience in individual counseling and family therapy refers to the number of years spent

providing individual counseling and family therapy. Previous work experience was assessed from responses to items found in the Therapy Experience Inventory.

Prior knowledge of family therapy refers to the student trainee's initial degree of knowledge of observational, conceptual, and therapeutic family therapy skills as measured by the Family Therapy Assessment Exercise (FTAE) (Breunlin et al., 1983).

Learning style was defined as the extent to which an individual emphasizes abstractness versus concreteness and action verses reflection in responding to the world. The Learning Styles Inventory (LSI) (Kolb, 1976, 1981, 1984), a nine-item self-description questionnaire that measures an individual's relative emphasis on four learning modalities (i.e., Concrete Experience (CE) or feeling, Reflective Observation (RO) or watching, Abstract Conceptualization (AC) or thinking, Active Experimentation (AE) or doing) was used to measure preferred learning style in this study.

Criterion Variables

For this study the criterion variables were the observational, perceptual, and therapeutic family therapy skills originally proposed by Cleghorn and Levin (1973) and later defined by Breunlin and colleagues (1983). The Family Therapy Assessment Scale (FTAE) (Breunlin et al., 1983) was used to assess these skills.

Observational family therapy skills refer to those skills required to perceive and describe behavioral interactions within a family session (Breunlin et al., 1983).

Conceptual family therapy skills refer to those skills that relate to the therapist's ability to understand a theoretical model that enable a therapist to classify distinctions according to that model (Breunlin et al., 1983).

Therapeutic family therapy skills refer to the therapist's ability to act in family sessions in ways that are consistent with goals of the training program (Breunlin et al., 1983).

Population

The population of interest consisted of graduate students enrolled in graduate-level introductory courses in structural/strategic family therapy as part of their academic training in marriage and family therapy. The criteria for inclusion of a program in the study were that (a) the course from which students were drawn was considered the entry phase of structural/strategic marriage and family therapy training in the graduate program, (b) the course focused on theoretical concepts drawn predominantly from structural/strategic family therapy, (c) the instructional focus was on learning how to assess for treatment planning, and (d) therapists

skills in structural/strategic family therapy assessment and interviewing were illustrated and simulated during the course. The population from which the sample for this study was drawn consisted of students enrolled in graduate degree programs located mainly in the northeastern and southeastern quadrants of the United States that were accredited or eligible for accreditation by the Commission on Accreditation for Marriage and Family Therapy Education. Of the 31 schools accredited by the Commission on Accreditation for Marriage and Family Therapy Education (as of February, 1990), 23 offered a master's degree and 8 offered a doctoral degree. Fourteen schools were contacted. Of those schools, 7 met the criteria for inclusion in the study sample and were invited to participate. In addition, 4 schools in the state of Florida that offered training in marriage and family therapy and met the accreditation requirements specified by the American Association of Marriage and Family Therapy accreditation were invited to participate. Three of those schools emphasized a structural/strategic approach in the initial phase of training and met the requirements for the study.

Sampling Procedures

The names of potential participating programs were obtained through the American Association for Marriage and Family Therapy (AAMFT) accredited programs located mainly

in the northeastern and southeastern regions of the United States, as well as eligible university programs in the state of Florida. General information regarding the nature of the training program, specific course focus and content, and potential willingness to participate in the study were obtained from the program chairperson by telephone interview. Those university programs offering an introductory family therapy course that appeared to meet the criteria previously specified were then contacted by phone and informed as to the nature of the study. Those instructors expressing an interest in participating in the study were sent a letter explaining the nature of the study (Appendix A), a questionnaire assessing the specific nature of their initial course content (Appendix B), as well as a request for the course syllabus. This questionnaire requested information on the required course goals and objectives, instructional activities, methods, and readings to determine whether the course experiences met the training criteria specified (see Appendix B). Specific instructional contents, readings, and methods were also verified (i.e., the emphasis on systems oriented patterns of conceptualization, assessment and therapy practice; a review of systemic and family developmental concepts; the description of assessment interview skills and student participation in role playing of an initial assessment interviews) by examining the course syllabus.

This procedure resulted in seven training programs being selected that met the general requirements for participation in the study. These programs were located at Purdue University, St. Thomas University, Southern Connecticut State University, Stetson University, Syracuse University, the University of Florida, and the University of Georgia. Students enrolled in these seven different course experiences were invited by their instructors to participate in the study by means of the following announcement (Appendix A):

> We are interested in studying the training of family therapists and we need your help. Specifically we would like to examine performance of trainees at the beginning and end of this course to assess their ability to look at interactional patterns and ways of working with families. Participation in the project requires you to view a videotape of a simulated family therapy interview. The tape will be stopped intermittently so that multiple choice questions concerning each segment of the interview can be answered. In addition, you will be asked to complete two brief questionnaires regarding your personal learning style and your training and work experience in the field of counseling/psychology and marriage and family therapy.
>
> Participation in this project is voluntary. The data collected for the project are not part of the class requirement, will in no way affect your participation in the class, and will not be viewed by the instructor to determine your grade. Participation in the project will be scheduled during class time at the beginning and end of the semester. The project will address several questions regarding effective training of marriage and family therapists. We are aware that it would be of some benefit to you as a participant, therefore, we are willing to give you personal feedback concerning your participation at the end of the project.

All information will be kept strictly confidential. Please feel free to ask any questions that you may have concerning the project.

Sample

The resulting sample consisted of a total of 99 students drawn from them five different training programs. One of the seven original schools was ommitted from the sample due to incomplete data sets. As can be seen in Table 1, 56% (56) of the sample were drawn from students in School 1, 4% (4) from School 2, 21% (21) from School 3, 9% (9) from School 4, and 9% (9) from School 5.

In this sample subjects ranged in age from 22 to 60 years of age. Approximately 48% (47) were between the ages of 22 to 30; 31% (31) were between the ages of 31 to 40; 14% (14) were between the ages of 41 to 50; 5% (5) were between the ages of 51 to 60, and 2% (2) did not list their age. In terms of ethnicity, 90.5% (86) of the students identified themselves as Caucasian, 3.2% (3) were Black, 3.2% (3) were Hispanic, 3.2% (3) were Asian, and 4% (4) did not respond to this question. Of the students, 74% (73) were female and 26% (26) were male.

As to marital status, 44% (44) of the students were never married; 35% (35) were married for the first time; 9% (9) were divorced; 6% (6) were remarried; 1% (1) was separated; and 4% (4) listed other (cohabitating). Of the sample, 31% (31) had children, with 69% (68) reporting no children.

Table 1

Frequency Distributions of Descriptive Variables for the Sample: Demographics (N=99)

	Number	Percent
Program		
School 1	56	56.6
School 2	4	4.0
School 3	21	21.2
School 4	9	9.1
School 5	9	9.1
	99	100.0
Age		
22-30	47	48.5
31-40	31	31.9
41-50	14	14.4
51-60	5	5.2
Not Given	2	
	100	100.0
Gender		
Male	26	26.3
Female	73	73.7
	99	100.0
Ethnicity		
Caucasian	86	90.5
Black	8	3.2
Hispanic	3	3.2
Asian	3	3.2
No Response	4	
	99	100.0
Marital Status		
Never Married	44	44.4
First Marriage	35	35.4
Divorced	9	9.1
Separated	1	1.0
Remarried	6	6.1
Other (Cohabitating)	4	4.0
	99	100.0
Children		
Children	31	31.3
No Children	68	68.7
	99	100.0

In terms of educational background, information was collected on previous educational experiences and degrees earned. All participating students had earned a bachelor's degree, with 30% (30) earning a master's degree; and 7% (7) listed other degree (i.e., Ed.S., Psy.D., Ph.D., other).

Concerning field of study for highest degree earned, 38% (38) earned a general psychology degree, 2% (2) listed counselor education, 3% (3) listed school psychology, 1% (1) listed rehabilitation counseling, and 50% (50) listed other field. With regard to current degree seeking status 87% (87) were seeking a degree at the present time, with 13% (13) in the matriculation process. Of the 87% actively seeking a degree, 50% (49) were in counselor education, 23% (23) listed marriage and family therapy, 2% (2) listed psychology, and 12% (12) listed other. Of the sample, 41% (40) were in their first year of study, 35% (35) in the second year, 9% (9) in the third year, 2% (2) in the fourth year, and 13% (13) in the process of matriculation.

Table 2

Frequency Distribution of Descriptive Variables of the Sample: Educational Background (N=99)

	Number	Percent
Highest Degree Earned		
Bachelor's	62	62.7
Master's	30	30.3
Ed.S.	3	3.0
Psy.D.	2	2.0
Ph.D.	1	1.0
Other	1	1.0
	99	100.0
Field of Study for Highest Degree Earned		
General Psych	38	38.5
Counselor Education	2	2.0
School Psych	3	3.0
Counseling Psych	2	2.0
	3	3.0
Rehabilitation Counseling	1	1.0
Other fields	50	50.5
	99	100.0
Degree Seeking		
Currently seeking a degree	85	85.9
In process of matriculation	14	14.1
	99	100.0
Degree Currently Seeking		
Counselor Education	49	49.5
Marriage and Family Therapy	23	23.3
Psychology	2	2.0
Other Degree Program (e.g., Family Studies)	12	12.1
In process of applying to degree program	13	13.1
	99	100.0
Year in Program		
1st year	40	40.4
2nd year	35	35.4
3rd year	9	9.1
4th year	2	2.0
Matriculating/application process	13	13.1
	99	100.0

Instrumentation

Three instruments were used in the study. One was investigator developed and was titled the Therapy Experience Inventory. The other two instruments, the Family Therapy Assessment Exercise and the Kolb Learning Styles Inventory, had been developed and used in other studies.

The Therapy Experience Inventory

Each subject was required to complete the Therapy Experience Inventory. This was developed by the researcher to obtain demographic information such as age, sex, and educational level and the extent of training and work experience in individual counseling/psychotherapy and in marriage and family therapy accrued by each student.

Prior training. Prior training consisted of two different aspects: (a) the amount of hours of coursework and (b) the amount of supervision hours. The amount of hours of coursework in individual counseling/psychotherapy was determined by assessing the number of academic courses completed by the subject in which the major focus was on individual counseling and psychotherapy. A course was defined as 3 credit hours or its equivalent of 48 contact hours. The amount of supervision was computed by determining the number of supervision hours received in individual counseling and psychotherapy. The two scores were derived for each subject. Training in the area of

marriage and family therapy was assessed by following the same procedure. Consequently, a total of two scores were calculated for each subject in both areas (i.e., individual counseling and family therapy).

Information was also collected to determine if students were involved in any other training experiences in marriage and family therapy during the time of the specified training experience. The number of courses and supervision hours obtained in marriage and family therapy was calculated for each subject at the posttest.

Prior work experience. Prior work experience in both (a) individual counseling and psychotherapy and (b) marriage and family therapy comprised this component. Work experience in individual counseling and psychotherapy consisted of the number of years (in quarter year increments) of direct experience in the practice of individually oriented therapy. Work experience in marriage and family therapy was assessed by the same procedure.

The Family Therapy Assessment Exercise

The Family Therapy Assessment Exercise was used to assess the level of trainee skills at pretesting and posttesting. Three skill areas were examined: observational, conceptual, and therapeutic. The Family Therapy Assessment Exercise was developed by Breunlin, Schwartz, Krause, and Selley (1983) for the purpose of assessing the level of observational, conceptual, and

therapeutic skills of trainees involved in structural/ strategic family therapy training program. The instrument consists of a videotape of a family therapy session and a series of multiple choice questions about the videotape.

This instrument was designed to assess the acquisition of skills within the structural/strategic model of family therapy. This model is a systemic integration of the structural family therapy of Minuchin and his colleagues (Minuchin, 1974; Minuchin & Fishman, 1981; Minuchin, Rosman, & Baker, 1978); the problem solving and strategic therapy of Haley and Madanes (Haley, 1976, 1980; Madanes, 1981); and the brief therapy of the MRI group (Watzlawick, Weakland, & Fisch, 1974); and the Ackerman Brief Therapy Project (Hoffman, 1981; Papp, 1980).

The knowledge subsumed under this model has been classified and operationalized in terms of three sets of interrelated skills; observational, conceptual, and therapeutic (Cleghorn & Levin, 1973; Tomm & Wright, 1979; Falicov, Constantine, & Breunlin, 1981). Observational skills were those required to perceive and describe behavioral interactions within a session. Conceptual skills were those inherent in a theoretical understanding of a model that, in this case, refers to the structural/ strategic model. Therapeutic skills were those necessary to execute interventions skillfully within the session according to the structural/strategic model. The FTAE

measured the therapist's ability to apply these three sets of skills to the clinical situation depicted in a videotape of a family therapy session.

Observational skills were measured by how perceptive the respondent was to behavioral data and sequences. Conceptual skills were measured by whether the respondent chose distinctions regarding observational data that correspond to structural/strategic principles. Because the respondent was observing a videotape of another person doing therapy, it was more difficult to assess the respondent's actual therapeutic skills. Some questions ask respondents to identify and evaluate the therapist's behavior on the videotape, others ask them to select a response that is closest to what they might do next if they were the therapist on the tape.

The videotape demonstrated a simulated family therapy interview. The therapist was presented as a doctor who has seen the family before and has been called in about the child's bedwetting problem. The family consisted of a mother, father, 10-year-old son, and 9-year-old daughter. As the tape begins, the children are playing with toys. When the doctor enters the room the mother attempts to get the children to put the toys away. They do not listen to her. The father intervenes by yelling at the children, and they put the toys away. The interview continues for approximately one hour. The tape was stopped

intermittently so that 34 multiple-choice questions concerning each segment of the interview can be answered.

The instrument was designed to measure the extent to which trainees acquired the three sets of skills: observational, conceptual, and therapeutic. Instructions for the exercise were self-explanatory. Subjects were asked to read instructions and encouraged to ask questions for clarification before the tape segment was presented. An overall score and three subtest scores for observational, conceptual, and therapeutic skills were computed for each trainee. Both total score and the subtest scores were used for the analyses in this study.

To date, five versions of the test have been written (and are in the process of being evaluated). The original instrument consisted of a videotape of an enacted family's first session and a series of multiple choice questions regarding the subject's perceptions, conceptualizations, and therapeutic recommendations about the tape. The subjects participating in the validation of this first form were 22 psychiatric residents who were given one month of family therapy training, and a control group that consisted of 11 pediatric residents who were not given family therapy training or any formal training in psychotherapy. A pretest-posttest assessment revealed a significant increase in conceptualizations skills for only family therapy trainees. There were no significant changes in either

observational (perceptual) or technical (executive) skills for either group. Breunlin et al. (1983) suggested that the instrument may not have been sensitive enough to detect a change in skill level.

The FTAE has since been revised. The fifth refinement is currently being used in research studies. The current version is a procedure in which subjects watch a simulated family therapy interview on videotape and answer the questions of a 32-item multiple-choice format test.

Although Breunlin et al. (1983) reported some difficulty with the discriminant validity of the observational scale, there is accumulating evidence that both the conceptual and therapeutic scales of the current version of the Family Therapy Assessment Exercise (FTAE) discriminate well, as does the total score (Hernandez, 1985; Pulleyblank & Shapiro, 1986; West, Hosie, & Zarski, 1985). For example, Hernandez (1985) assessed the discriminant validity of the FTAE using a sample of 75 persons who were either novice, mid-range, or experienced family therapists. Subjects were drawn from seven family therapy training programs in Illinois and Indiana and ranged from first year graduate students to AAMFT approved supervisors. Three- and six-week test-retest reliabilities for the FTAE overall score were .76 and .62, respectively. Hernandez (1985) reported that the total score, conceptual

score, and the therapeutic (executive) score discriminated well between novice and experienced therapists.

In another study, Pulleyblank and Shapiro (1986) used the FTAE to evaluate a structural family therapy training program and found that all the scores of the FTAE differentiated between trainees in a structural family therapy training program and a comparison group. However, generalizability of the study was limited due to the small sample size of nine.

West et al. (1985) examined 10 students enrolled in a graduate level course in family therapy who practiced interviewing simulated families over a period of 4½ months (one semester). Students were novice-level family therapists. Skill development was assessed at three equal interval times during the semester. The FTAE was used to measure skill development. A repeated measures analyses indicated there were significant differences between testing times on the total score. Significant differences were found from time 1 to time 3 with combined scores for observational and conceptual subtests. Conceptual skills increased significantly from time 1 to time 2, and observational skills significantly increased from time 2 to time 3.

No significant differences were found for the therapeutic subtest. This may be due to two factors: the test instrument and the method of training that emphasized

observational and conceptual skills. However, the study does lend support to the validity of the FTAE and suggests the use of simulation for skill development of observational and conceptual skills.

Kolb Learning Style Inventory

The Kolb Learning Style Inventory (LSI) was used to assess the learning style of the trainee. Four styles were assessed by this instrument. The Kolb Learning Style Inventory is a nine-item self-description questionnaire. In each item the respondent is asked to rank order four words that best describes his or her learning style. One word in each item corresponds to one of four learning modes described by Kolb (1976). These are Concrete Experience (CE) mode (sample word-feeling), the Reflective Observation (RO) mode (e.g., watching), the Abstract Conceptualization (AC) mode (e.g., thinking), and the Active Experimentation (AE) mode (e.g., doing). The LSI was designed to measure a person's report of the relative emphasis they give to using each of the four modes of learning depicted. Thus each person's learning style is a combination of the four basic learning modes yet is a single data point that combines scores on the four basic modes to describe an individual's learning style. Computation of this learning score was accomplished by computing two combination scores that indicate the extent to which the person emphasized abstractions over concreteness (AC-CE) and the extent to

which the person emphasized action over reflection (AE-RO). These two combination scores, AC-CE and AE-RO, were then plotted with their point of interception falling into one of four dominant learning style quadrants: Accommodator, Diverger, Converger, or Assimilator. In the study the two combination scores were used for the analyses, thus two continuous variables were examined. The interaction of the two combination scores (AC-CE) and (AE-RO) were also examined.

Norms for scores on the LSI were developed from samples of 1,933 men and women ranging in age from 18 to 60 and representing a wide variety of occupations. These norms, along with reliability and validity for the LSI, were reported in detail by Kolb (1976, 1981). Kolb (1981) emphasized that this was not a measure of a stable psychological trait but a construct that was theoretically conceived of as a situational variable. Test-retest coefficients were highest when the test-retest time period was short and the experience in test-retest was highly similar to the previous experience (i.e, when there is no great change in situational circumstances). Split-half reliability coefficients for the two combination scores of AC-CE and AE-RO were .70 under the previously stated circumstances, however average .50 under a wide variety of circumstances (time period and situational circumstances).

Split-half reliabilities for the LSI combination scores of AC-CE and AE-RO were .80 (Kolb, 1987).

Data Collection

Data were collected on trainees enrolled in graduate level family therapy courses from Purdue University, Southern Connecticut State University, St. Thomas University, Syracuse University, the University of Florida, and the University of Georgia, over several semesters in order to allow for an adequate number of volunteers because classes were typically small. Each subject was told that he or she was participating in a family therapy training study that would take approximately 2 hours of pretesting and 1 hour of posttesting. Those subjects who agreed to participate were scheduled for testing administered by the instructor.

Pretesting

Pretesting was scheduled within the first two weeks of the family therapy seminar. Subjects met with their instructor and received the following instructions. The first task required of the subjects was to read and sign the informed consent (Appendix C), followed by the Therapy Experience Inventory (i.e., demographic questions, prior level of training, work experience, supervision, etc.) (Appendix D). Next, subjects completed the Kolb Learning Styles Inventory. Instructions for completing the inventory were printed on the inventory itself, thus

subjects were asked to read the instructions and complete the inventory (Appendix E). Upon completion of this, subjects were administered the Family Therapy Assessment Exercise (FTAE). All subjects were given the instructions as per the FTAE instrument (Appendix F). Basically, subjects were shown a videotaped interview of a family therapy session and instructed to answer questions about this interview using the FTAE questionnaire.

Posttesting

The Therapy Experience Inventory and the Family Therapy Assessment Exercise (FTAE) were administered a second time to all subjects (See Appendices C and E). The instructor scheduled and administered post-testing during the last week of the 16 week semester. A stamped, addressed return-envelope was provided for each instructor who was asked to mail to the researcher all instruments after the posttesting was completed.

Hypotheses

The following hypotheses were tested in this study:

1. There is a significant difference from pretesting to posttesting in the levels of family therapy skills, as measured by the Family Therapy Assessment Exercise, of students participating in the initial phase of family therapy training.

2. The greater the amount of initial knowledge of family therapy skills, as indexed by the Family Therapy

Assessment Exercise pretest, the less the amount of change in family therapy skill levels from pretesting to posttesting among participating students.

3. The greater the amount of prior training in individual therapy, as indexed by the Family Therapist Experience Inventory, the less the amount of change from pretesting to posttesting in family therapy skills among participating students.

4. The greater the amount of prior work experience conducting individual therapy, as indexed by the Family Therapist Experience Inventory, the less the amount of change in family therapy skills among participating students as measured by the Family Therapy Assessment Exercise.

5. The greater the amount of prior training in family therapy, as indexed by the Family Therapist Experience Inventory, the less the amount of change from pretesting to posttesting in family therapy skill levels.

6. The greater the amount of prior work experience in family therapy, as indexed by the Family Therapist Experience Inventory, the less the amount of change from pretesting to posttesting in family therapy skill levels of participating students.

7. The more divergent the thinking style of the student as measured by the Kolb Learning Inventory, the

greater the amount of change from pretesting to posttesting in student's family therapy skill levels.

Data Analysis

To test these hypotheses, the data were coded and analyzed by computer using SPSSX. Participant data records were discarded only if entire responses sets were absent for particular instruments. Preliminary analysis of the data was conducted to ascertain whether there were differences by training program in the nature of student skill acquisition. Analyses of covariance of participant total FTAE skill scores from pretesting to posttesting by school were conducted for this purpose. By dependent sample T-tests were then conducted on pretest and posttest scores for the group as a whole to test Hypothesis one. Multiple regression analyses were conducted to test Hypothesis two through seven. These specific data analytic procedures and results are described in Chapter IV.

CHAPTER IV
RESULTS

This study was designed to examine the levels of family therapy skill acquisition of student therapists participating in the initial phase of academic family therapy training. A second purpose of the study was to examine the influence of four specific trainee characteristics on the acquisition of family therapy skills by these participants. The sample consisted of 99 family therapy students enrolled in introductory structural/strategic family therapy courses at one of five different universities. In this chapter, the results of the study are presented as they pertain to each of the research questions and hypotheses posed.

Preliminary Analysis

An analysis of covariance (ANCOVA) was performed to assess whether the subjects from each of the participating training programs differed significantly in their skill acquisition from pretesting to posttesting. The purpose of the analyses of covariance (ANCOVA) was to establish equivalency among programs and programs effects. In this way the program component could be considered as one construct. An ANCOVA was used to analyze the Family

Therapy Assessment Exercise (FTAE) pretest and posttest scores of students from each of the six participating schools (see Table 3). Results of this analysis revealed a significant difference by school ($F = 3.60$, $p = .0049$). Dunn's test of the adjusted posttest means revealed that one school differed significantly from the other five. This school was deleted from the final sample and a second ANCOVA was conducted on student scores for the remaining five schools as can be seen in Table 4. Results from this second analysis revealed no significant differences among schools ($F = 2.27$, $p < .0678$).

Table 3

Analysis of Covariance of Student FTAE Scores by School for Six Participating Schools

Source	SS	df	MS	F	p
PRE	891.66	1	891.66	75.26	.0001
School	212.97	5	42.59	3.60	.0049
Error	1220.28	103	11.84		
Total	2324.92	109			

Descriptive Statistics

In the first research question, how beginning family therapy students could be described in terms of (a) their age, (b) extent of previous training (i.e., coursework and

clinical supervision), (c) extent of work experience, (d) extent of prior family therapy knowledge, and (e) type of learning style preferred was addressed. Means and standard deviations were computed for these variables and are presented in Table 5. In addition, frequency distributions were computed for each of the variables with the exception of the variable, extent of prior family therapy knowledge.

Table 4

Analysis of Covariance of Student FTAE Scores by School for Five Participating Schools

Source	SS	df	MS	F	p
PRE	800.77	1	800.77	65.43	.0001
School	110.99	4	27.75	2.27	.0678
Error	1138.24	93	12.24		
Total	2050.00				

As can be noted, the students reported an average age of 32.9 (SD = 8.89) with a possible range of 22-60 years. Forty-eight percent (47) were between the ages of 22 to 30; 31% were between the ages of 31 to 40; 14% (14) were between the age of 41 to 50; 5% were between the ages of 51 to 60, and 2% (2) did not list their age (Table 6).

In terms of prior training in individual counseling and marriage and family therapy both number of courses and supervision hours were assessed to determine the extent of

prior training in each area. The average number of courses in individually oriented counseling/ psychotherapy for each trainee was 7.69 (SD = 9.62) with a range of 0-73 courses (Table 7).

Table 5

Means and Standard Deviations of Trainee Characteristics (N=99)

Variable	Mean	SD
Age	32.9	8.89
Courses (Individual Counseling)	7.69	9.62
MF Courses	.74	1.08
Supervision Hours (Individual)	30.32	103.49
Supervision Hours (MFT)	5.33	23.46
Individual Years Experience	152.77	233.53
MF Years Experience	27.52	93.30
ACCE	-.49	6.98
AERO	1.56	6.31
LSIINT	4.72	46.78
Extent of Prior Knowledge of Family Therapy	12.9	3.90

Approximately 50% (50) of the sample had taken 0-5 courses, 23% (23) had taken 6 to 10 courses; 15% (15) had taken 11 to 15 courses; 5% (5) had taken 6 to 20 courses,

and 6% (6) had taken 21 to 73 courses (Table 7). Seventy-three percent of the sample had completed 10 or fewer classes in individual counseling/psychotherapy. The number of family therapy courses completed averaged .74 (SD = 1.08) with a 0-6 range. Fifty-four percent (54) of the sample had received no coursework in marriage and family therapy; 28% (28) had completed one course, 9.1% (1) had completed 2 courses; 6.1% (6) completed 3 courses, 1% (1) had completed 4 courses; and 1% (1) had completed 6 courses (Table 7). Thus 94% (94) of the sample had completed 2 courses in family therapy or less.

Table 6

Frequency Distribution for Trainee Age (N=99)

Age	Number	Percent
22 - 30	47	48.5
31 - 40	31	31.9
41 - 50	14	14.4
51 - 60	5	5.2
Not Given	2	--
	99	100

In terms of the number of hours of clinical supervision in individual counseling/ psychotherapy this sample of students averaged 30.32 (SD = 103.49) with a

Table 7

Frequency Distribution for Amount of Prior Training for Individual Counseling and Marriage and Family Therapy (N=99)

	Number	Percent
Number of Individual Counseling Courses		
0 - 5	50	50.4
6 - 10	23	23.3
11 - 15	15	15.2
16 - 20	5	5.0
21 - 73	6	6.1
	99	100.0
Number of Marriage Family Therapy Courses		
0	54	54.5
1	28	28.3
2	9	9.1
3	6	6.1
4	1	1.0
6	1	1.0
	99	100.0
Supervision Hours for Individual Counseling		
0	54	54.6
1 - 25	28	28.3
26 - 50	7	7.1
51 - 100	3	3.0
101 - 150	2	2.0
151 - 200	2	2.0
201 - 300	2	2.0
301 - 899	1	1.0
	99	100.0
Supervision Hours for Marriage & Family Therapy		
0	83	83.9
1 - 25	12	12.1
26 - 50	1	1.0
51 - 100	1	1.0
101 - 150	2	2.0
	99	100.0

range of 0 - 899 (Table 5). Approximately 54% (54) of the trainees received no supervision in individual counseling; 28.3% (28) received 1-25 hours; 7.1 % (7) received 26-50 hours; 3% (3) received 51-100 hours; 2% (2) received 101-150 hours; 2% (2) received 151-200 hours; 2% (2) received 200-300 hours; and 1% (1) received 301-899 hours (Table 7). More than half of the trainees had received no supervision in individual counseling/psychotherapy. An additional 25% received less than 15 hours. For marriage and family therapy supervision hours the average number of hours for the group was 5.33 (SD = 23.46) with a range of 0-150 (Table 5). Of this group, 83.9% (83) had received no supervision in marriage and family therapy; 12.1% (12) received between 1 and 25 hours of supervision; 1% (1) received 26 to 50 hours; 1% (1) received between 51 to 100 hours; and 2% (2) perceived 101 to 150 hours (Table 5). Ninety-one percent of the group received less than 5 hours of supervision.

The amount of trainee work experience was also examined. This was coded in yearly quarters (i.e., .25 = ¼ year). The average amount of individual counseling/ psychotherapy work experience for the group was 1½ years (152.77; SD = 233.53) with a range of 0-12 years (0-1200) (Table 3). Approximately one-third (32.4%) had no work experience; 13.1% (13) had obtained ¼ of a year of experience, 9.1% (9) obtained ¼ to ½ of a year; 3% (3)

obtained ½ to ¾ of a year; 10.1% (10) obtained ¾ to 1 year; 10.1% (10) received 1 to 2 years; 8.1% (8) obtained 2 to 3 years; 7.1% (7) obtained 3 to 5 years; 5% (5) obtained 5 to 8 years; and 2% (2) received 8 to 12 years (Table 6). Thus, 67% of the sample had less than one year of work experience in individual counseling, with an additional 10% having 2 years or less experience. In terms of marriage and family therapy work experience, the sample as a whole averaged approximately ¼ year (27.52; SD = 93.30) with a range of 0-8 years (0-800) (Table 5). However, 75.7% had no work experience in marriage and family therapy; 8.1% (8) obtained ¼ year; 5.1% (5) obtained ¼ to ½ of a year; 1% (1) obtained ½ to ¾ of a year; 5.1% (5) obtained ¾ to 1 year; 2% (2) obtained 1 to 2 years; 2% (2) obtained 2 to 3 years; and 1% (1) obtained 3 to 8 years (Table 8). Thus, 75% of the group had obtained no work experience in marriage and family therapy while an additional 13% had less than ½ year of work experience.

The extent of prior knowledge of family therapy (PFK) was assessed by calculating the pretest total score on the Family Therapy Assessment Exercise (FTAE) for each participant. The students demonstrated an average pretest score of 12.9 (SD = 3.9) on a possible scale range of 32 (Table 5).

Table 8

Frequency Distribution for Amount of Prior Work Experience in Individual Counseling and Marriage and Family Therapy (N=99)

	Number	Percent
Work Experience in Individual Counseling		
0	32	32.4
0 - ¼ year	13	13.1
¼ - ½ year	9	9.1
½ - ¾ year	3	3.0
¾ - 1 year	10	10.1
1 - 2 years	10	10.1
2 - 3 years	8	8.1
3 - 5 years	7	7.1
5 - 8 years	5	5.0
8 - 12 years	2	2.0
	99	100
Work Experience in Marriage & Family Therapy		
0	75	75.7
0 - ¼ year	8	8.1
¼ - ½ year	5	5.1
½ - ¾ year	1	1.0
¾ - 1 year	5	5.1
1 - 2 years	2	2.0
2 - 3 years	2	2.0
3 - 8 years	1	1.0
	99	100

*Work Experience is assessed in ¼ year increments

Of great interest were the various learning styles preferred by the participants. The learning style measure yielded four possible styles. Frequencies were computed for

each learning style. These are presented in Table 9. As can be noted four learning styles were possible from the two style dimensions assessed. The participants reported the following preferences: 51.6% (51) characterized themselves as divergers, 13.1% (13) as convergers, 17.1% (17) as accommodators, and 20.2% (20) as assimilators.

Means and standard deviations for trainee age, coursework, supervision hours, work experience, prior knowledge of family therapy, and learning style variables were also computed for each of the five participating universities (See Appendix G).

Table 9

Frequency Distribution for Preferred Learning Style of the Trainee (N=99)

Learning Style Category	Number	Percent
Diverger	51	51.6
Converger	13	13.1
Accommodator	17	17.1
Assimilator	20	20.2
	99	100.0

Hypotheses

In the first hypothesis, significant differences from pretesting to posttesting in levels of family therapy skills

of students participating in the initial phase of family therapy training were predicted. A series of t-tests were calculated to test the levels of significance of the change scores on the Family Therapy Assessment Exercise (FTAE) overall score and three subscales. As can be seen in Table 10, significant differences between pretests and posttests were noted for the FTAE total skill score ($t = 9.15$, $p < .001$), the descriptive skill score ($t = 2.05$, $p < .05$), the conceptual skill score ($t = 4.67$, $p < .0001$), and the therapeutic skill scores ($t = 7.55$, $p < .0001$). Based on these results, Hypothesis 1 is accepted.

Table 10

Results of t-tests for the FTAE Overall (Total) Score and Descriptive, Conceptual, and Therapeutic Subscales

FTAE	Pretest Mean	Posttest Mean	t	p
Total Score	12.9	16.3	9.15	.0001
Descriptive	3.1	3.4	2.05	.04
Conceptual	4.9	6.1	4.67	.0001
Therapeutic	4.9	6.8	7.55	.0001

To test hypotheses two through seven which examined the relationship between each trainee characteristic and the acquisition of family therapy skills a series of regression analyses were performed. Prior to conducting these

analyses, a series of correlations were computed to determine the degree of intercorrelations among the variables.

Intercorrelations

Intercorrelations among the trainee variables of work experience, coursework, supervision hours, and continuing education credits (CEU's) in marriage and family therapy were computed (Table 11). Work experience in marriage and family therapy was significantly correlated with individual work experience, supervision in individual counseling, and supervision in marriage and family therapy. Work experience in individual counseling was significantly correlated with marriage and family therapy work experience, supervision in individual counseling, supervision in marriage and family therapy, and coursework in individual counseling. In addition to this there was a negative correlation between work experience in individual counseling and continuing education credits (CEU's) in marriage and family therapy.

There were no significant correlations with coursework in marriage and family therapy. Individual counseling coursework was significantly correlated with work experience in individual counseling and supervision in individual counseling. As previously mentioned continuing education credits (CEU's) in marriage and family therapy were negatively correlated with work

Table 11

Intercorrelations Among Trainee Variables

	MF yrs. Exp.	Ind. yrs. Exp.	MF courses	MF Superv.	Indiv. Courses	Indiv. Superv.	CEU MFT	ACCE	AERO	LSIINT
MF Yrs. Exp.	1.00	.59	.009	.61	.07	.22	-.11	.10	-.03	.11
	.00	.0001	.9303	.0001	.5167	.0266	.29	.3179	.7314	.2632
Ind. Yrs. Exp.	.59	1.00	.09	.47	.21	.26	-.22	.03	.02	.05
	.0001	.00	.3884	.0001	.0332	.0089	.0309	.7992	.8333	.6120
MF Courses	.009	.09	1.00	.17	-.13	.08	-.20	-.06	-.16	-.005
	.9303	.3884	.00	.2511	.2174	.4475	.0588	.5555	.1044	.9624
MF Supervision	.61	.47	.17	1.000	.04	.57	-.11	-.07	-.06	.11
	.0001	.0001	.2511	.00	.6683	.0001	.2573	.4860	.5469	.2648
Courses (Ind.)	.07	.21	-.13	.04	1.000	.30	.10	.03	-.13	.02
	.5167	.0332	.2174	.6683	.00	.0022	.3136	.7869	.2006	.8770
Supervision (Ind.)	.22	.26	.08	.57	.30	1.000	-.005	-.16	-.18	.12
	.0266	.0089	.4475	.0001	.0022	.00	.9582	.1194	.0676	.2191
CEUMFT	-.11	-.22	-.19	-.11	.10	-.005	1.000	-.001	-.11	-.04
	.2979	.0309	.0588	.2573	.3136	.9582	.00	.9890	.2931	.6736
ACCE	.10	.03	-.06	-.07	.03	-.16	-.001	1.000	.13	.43
	.3179	.7992	.5555	.4860	.7869	.1194	.9890	.00	.2135	.0001
AERO	-.03	.02	-.16	-.06	-.13	-.18	-.11	.13	1.000	-.09
	.7314	.8333	.1044	.5469	.2006	.07	.2931	.2135	.00	.3886
LSIINT	.11	.05	-.005	.11	.02	.12	-.04	.43	-.09	1.000
	.2632	.6120	.9624	.2648	.8770	.2191	.6736	.0001	.3886	.00

experience in individual counseling. No other correlations for this variable existed. The amount of supervision hours in marriage and family therapy were significantly correlated with work experience in marriage and family therapy, work experience in individual counseling, and supervision in individual counseling.

The amount of supervision hours in individual counseling were significantly correlated with work experience in both individual counseling and in marriage and family therapy, supervision in marriage and family therapy, and coursework in individual counseling.

Regarding the learning style variables (ACCE, AERO, and LSIINT), the only significant correlation was between the ACCE dimensions and the LSIINT score. No other significant correlations were found among trainee variables.

Correlations for the selected personal characteristics of the trainee and the Family Therapy Assessment Exercise (FTAE) overall scale and three subscales are listed in Table 12. Significant correlations were few. The pretest FTAE overall scale (PREFO) was negatively correlated with the change score, positively correlated with its three pretest subscales (PREFD, PREFC, PREFT), and positively correlated with the posttest FTAE overall scale (PostFO) and three subscales (PostFD, PostFC, PostFT). The posttest FTAE overall scale (PostFO) was positively correlated with

the change score, and positively correlated with the pretest FTAE overall scale (PREFO) and three subscales (PREFC, PREFD, PREFT).

The pretest FTAE descriptive subscale (PREFD) was negatively correlated with the change score, positively correlated with the pretest overall scale (PREFO), the pretest conceptual subscale (PREFC), and the pretest therapeutic subscale (PREFT). The pretest FTAE descriptive subscale (PREFD) was also positively correlated with posttest FTAE overall scale (PostFO), the posttest FTAE conceptual subscale (PostFC), and therapeutic subscale (PostFT). The posttest FTAE descriptive subscale (PostFD) was positively correlated with the change score and with the pretest FTAE overall scale (PREFO) and pretest FTAE therapeutic subscale (PREFT). In addition to this the FTAE posttest descriptive subscale (PostFD) was positively correlated with individual therapy supervision hours and with the LSIINT (Learning Style Inventory interaction score).

The pretest FTAE conceptual subscale (PREFC) was negatively correlated with the change score, positively correlated with the pretest overall scale (PREFO) and the pretest descriptive (PREFD) and therapeutic (PREFT) subscales. It was also correlated with the posttest FTAE overall scale (PostFO)and the posttest conceptual (PostFC) and therapeutic (PostFT) subscales. The posttest FTAE

Table 12

Intercorrelations Among Independent and Dependent Trainee Variables

Variable	CHANGE	PRE FO	PRE FD	PRE FC	PRE FT	POST FO	POST FD	POST FC	POST FT
FMT yrs. Exp.	-.03	.10	.06	.12	.05	.06	-.14	.09	.09
Ind. yrs. Exp.	.10	.11	.10	.10	.07	.18	.07	.15	.16
MF Courses	-.03	.03	.13	-.06	.03	-.006	.06	-.04	-.004
MF Supervision	-.01	.11	.09	.13	.04	.08	-.09	.06	.13
Courses	.07	.03	.02	-.03	.07	.08	.03	.03	.10
Supervision	.05	-.12	.06	-.17	-.10	-.06	-.20	-.02	.0009
CEU MFT	-.17	-.004	-.18	.02	.06	-.14	-.07	-.07	.16
NMF Classes	-.06	.08	.07	.0007	.11	.11	-.04	.16	.10
ACCE	-.08	.10	.06	.008	.14	.02	.05	-.03	.03
AERO	.02	.11	-.03	.12	.11	.11	.11	.14	.04
LSIINT	-.03	-.17	-.13	-.16	-.10	-.17	-.21*	-.11	-.11
Change	1.00	-.28*	-.23*	-.22*	-.19	.58*	.33*	.44*	.50*
PRE FO	-.28*	1.000	.59*	.79*	.82*	.63*	.33*	.47*	.56*
PRE FD	-.23*	.59	1.000	.34*	.27	.31*	.10	.24*	.31*
PRE FC	-.22*	.80	.34*	1.000	.40	.49*	.16	.44*	.43*
PRE FT	-.19	.82	.27*	.40*	1.000	.55*	.40*	.36*	.48*

* $p < .05$

conceptual subscale (PostFC) was positively correlated with the change score and with the pretest FTAE overall scale (PREFO) and three subscales (PREFC, PREFD, PREFT).

Regression Analyses

A series of multiple regression analyses were performed to predict performance on the Family Therapy Assessment Exercise (FTAE) overall scale and three subscales. Each equation had the same 10 predictor variables which were as follow: the respective FTAE pretest used to measure initial knowledge of family therapy, extent of individual counseling coursework, extent of marriage and family therapy coursework, amount of supervision hours in counseling, amount of supervision hours in marriage and family therapy, amount of work experience in individual counseling, amount of work experience in marriage and family therapy, and the Learning Style Inventory ACCE, AERO, and LSIINT dimensions.

In order to account for any additional training effects occurring during the time of the specified training experience, information was collected from all participants regarding simultaneous training experiences accrued in marriage and family therapy at the time of the posttest. The number of courses in marriage and family therapy were calculated and frequencies were computed (Table 13). As can be seen, 69.7% (69) of the students received no concurrent supervision in marriage and family therapy,

13.1% (13) received 1 hour; 8.1% (8) received 2 hours, and 9.1% (9) received 3 hours. Because the amount of supervision hours received by students was so limited, no additional analysis for this component of training was computed.

Regarding the amount of additional coursework in marriage and family therapy received in conjunction with the designated training experience, 67.7% (67) of the students obtained no additional coursework, 30% (30) obtained one additional course in marriage and family therapy; and 2% (2) reported taking 2 additional courses. Therefore the number of additional courses taken in marriage and family therapy was included in the regression analyses to account for the possibility of any simultaneous training effects. Thus, the regression analyses included the 10 initial predictor variables, and in addition to this an 11th variable, the number of additional courses taken in marriage and family therapy (see Table 14).

Results of the first regression analysis is presented in Table 15. The FTAE posttest overall scale (Post FO) was significant ($F = 5.878$, $p < .0001$) with an R^2 equal to .43. As shown in Table 15 only the pretest was a significant predictor ($p < .0001$). A priori analyses were conducted for the three subscales of the FTAE. The results of the regression analysis for the descriptive subscale of the FTAE is presented in Table 16. There were no significant

Table 13

Frequency Distribution for Supervision Hours Accumulated During the Specified Training Courses (N=99)

Supervision Hours	Number	Percent
0	69	69.7
1	13	13.1
2	8	8.1
3	9	9.1
	99	100.0

Table 14

Frequency Distribution for Additional Marriage and Family Therapy Classes taken in Conjunction with the Specified Training Courses

Additional MFT Classes	Number	Percent
0	67	67.7
1	30	30.3
2	2	2.0

predictors for the FTAE posttest descriptive subscale (Post FD) with ($F = 1.505$, $p < .1436$) with an R^2 equal to .1599. The results of the regression analysis for the posttest conceptual subscale (Post FC) was significant ($F = 2.665$, $p < .0055$) with an R^2 equal to .25. As shown in Table 16 the pretest was the only significant predictor ($p < .0001$).

The results for the regression analysis for the posttest FTAE therapeutic subscale is shown in Table 17.

Table 15

Regression Model for the Relationship Between the Posttest FTAE Overall Score and the Selected Personal Characteristics of the Marriage and Family Therapy Trainee

Parameter	Estimate	SE	T for Ho Parameter = 0	p
Intercept	6.7	1.4	4.7	.0001
PREO	6.9	.10	7.0	.0001
Courses (Individual)	.02	.04	.47	.6430
MF Courses	-.17	.36	-.47	.6430
Supervision	-.001	.005	.24	.8054
MF Supervision	.006	.03	.25	.8024
Individual Work Experience	.003	.002	.60	.1123
MF Work Experience	-.004	.006	-.72	.4483
ACCE	-.01	.06	-.16	.8745
AERO	.02	.06	.37	.7149
LSIINT	-.007	.009	-.77	.4440
Additional MF Classes	.91	.76	.21	.2300

F = (5.878) $p < .0001$ R-square = .4263

The posttest FTAE therapeutic subscale was significant ($F = 2.878$, $p < .0029$) with an R^2 equal to .27. Again, only the pretest was a significant predictor ($p < .0001$) in the model (Table 18).

Table 16

Regression Model for the Relationship Between the Family Therapy Assessment Exercise (FTAE) Descriptive Subscale and the Selected Personal Characteristics of the Marriage and Family Therapy Trainee

Parameter	Estimate	SE	T for Ho Parameter = 0	p
Intercept	3.12	.39	8.07	.0001
PREFD	.05	.11	.48	.64
Courses (Individual)	.01	.01	.83	.41
MF Courses	.07	.11	.64	.53
Supervision	-.003	.002	-1.9	.07
MF Supervision	.007	.007	.95	.35
Individual Work Experience	.001	.0006	1.56	.12
MF Work Experience	-.004	.002	-2.0	.05
ACCE	.02	.02	1.1	.28
AERO	.008	.02	.46	.65
LSIINT	-.006	.003	-1.92	.06
Additional MF Classes	-.01	.23	-.04	.97

F = (1.505) $p < .1436$ R-square = .1599

Table 17

Regression Model for the Relationship between the Family Therapy Assessment Exercise (FTAE) Conceptual Subscale and the Selected Personal Characteristics of the Marriage and Family Therapy Trainee

Parameter	Estimate	SE	T for Ho Parameter = 0	p
Intercept	3.47	.60	5.74	.0001
PREFC	.44	.11	4.20	.0001
Courses	-.0008	.02	-.039	.97
MF Courses	-.07	.18	-.41	.68
Supervision	.001	.002	.59	.58
MF Supervision	-.006	.01	-.51	.61
Individual Work Experience	.001	.001	1.3	.06
MF Work Experience	.0003	.003	.112	.10
ACCE	-.008	.03	-.25	.80
AERO	.03	.03	.87	.39
LSIINT	-.0025	.005	-.54	.59
Additional MF Classes	.69	.36	1.91	.91

F = (2.665) $p < .0055$ R-square = .2520

Table 18

Regression Model for the Relationship Between the Family Therapy Assessment Exercise (FTAE) Therapeutic Subscale and the Selected Personal Characteristics of the Marriage and Family Therapy Trainee

Parameter	Estimate	SE	T for Ho Parameter = 0	p
Intercept	3.75	.71	5.3	.0001
PREFT	.57	.12	4.5	.0001
Courses	.02	.03	.52	.60
MF Courses	-.13	.25	-.51	.61
Supervision	-.001	.003	-.44	.66
MF Supervision	.02	.02	.97	.34
Individual Work Experience	.001	.001	.99	.33
MF Work Experience	-.002	.004	-.39	.70
ACCE	.005	.04	.12	.90
AERO	-.01	.04	-.27	.79
LSIINT	-.006	.006	-.93	.36
Additional MF Courses	.58	.52	1.02	.31

F = (2.878) $p < .0029$ R-square = .2668

In hypothesis two it was predicted that the greater the amount of initial knowledge of family therapy skills as indexed by the Family Therapy Assessment Exercise (FTAE) pre-test, the less the amount of change from pretesting to posttesting among participating students. A series of Pearson product moment correlation coefficients were computed to assess the association between the FTAE total score and the change score and for the three subscales scores and the change score. As can be seen in Table 9, these scores were significantly varied in an inverse direction with the change score. The higher the initial knowledge score, the smaller the size of the change score from pretesting to posttesting. In the series of regression equations (Tables 14, 15, 16, and 17) the extent of initial knowledge of family therapy (PREFO) was a significant predictor for the overall FTAE score, and for the conceptual and therapeutic subscales. Thus, hypothesis two was supported.

For hypothesis three it was predicted that the greater the amount of prior training in individual therapy, as indexed by the Family Therapy Experience Inventory the less the amount of change in family therapy skill levels from pretesting to posttesting among participating students. A series of regression equations were computed to assess the relationship

among these variables. As depicted in Tables 14, 15, 16, and 17, the level of individual training did not significantly predict the FTAE change scores. Therefore, hypothesis three was not supported.

For hypothesis four, it was predicted that the greater the amount of prior work experience conducting individual therapy, as indexed by the Family Therapy Experience Inventory, the less the amount of change from pretesting to posttesting in family therapy skills among the participating students as measured by the Family Therapy Assessment Exercise (FTAE). Results of the regression equations performed to assess the relationship among the FTAE change scores and the levels of individual work experience shown in Tables 14, 15, 16, and 17 revealed that the level of individual work experience was not a significant predictor for the FTAE change scores. Thus hypothesis four was not supported.

For hypothesis five, it was predicted that the greater the amount of prior training in family therapy, as indexed by the Family Therapy Experience Inventory, the less the amount of change from pretesting to posttesting in family therapy skill level among participating students. Results of the regression equations computed to assess the relationship between the FTAE change scores and the level of training in

marriage and family therapy, as depicted in Tables 14, 15, 16, and 17, reveals that the level of training in marriage and family therapy was not a significant predictor for the FTAE change scores. Therefore, hypothesis five was not supported.

For hypothesis six, it was predicted that the greater the amount of prior work experience conducting marriage and family therapy, as indexed by the Family Therapy Experience Inventory, the less the amount of change from pretesting to posttesting in family therapy skill levels of participating students as measured by the Family Assessment Exercise (FTAE). Results of the regression equations conducted to assess the relationship between the FTAE change scores and the amount of prior work experience conducting marriage and family therapy shown in Tables 14, 15, 16, and 17 revealed that the amount of prior work experience conducting marriage and family therapy was not a significant predictor for the FTAE change scores. Thus, hypothesis six was not supported.

For hypothesis seven, it was predicted that the more divergent the learning style of the trainee as measured by the Kolb Learning Styles Inventory, the greater the amount of change from pretesting to posttesting in student's family therapy skill levels. Results of regression equations conducted to assess the

relationship among the FTAE change scores and preferred learning style of the trainee (ACCE, AERO, LSIINT), as shown in Tables 14, 15, 16, and 17, revealed that the learning style of the trainee was not a significant predictor for the FTAE change scores. Therefore, hypotheses seven was not supported.

Summary

A preliminary analysis of covariance (ANCOVA) was performed to assess whether the subjects from each training program differed significantly in their skill acquisition from pretesting to posttesting. Results indicated that one school significantly differed from the other five schools. Thus, this school was deleted from the sample. A second ANCOVA was performed which indicated no significant differences among the five remaining schools.

Descriptive statistics were computed in order to describe family therapy students in terms of age, extent of previous training (coursework and supervision), extent of work experience, extent of prior knowledge of family therapy, and preferred learning style. Trainees were relatively young with a limited amount of prior training and work experience. Of four possible learning styles, more than 50% of the participants described themselves as divergers.

Results revealed significant changes in skill acquisition after the initial phase of training. In examining the relationship between trainee characteristics and skill changes the initial knowledge of family therapy was correlated in an inverse direction with skill acquisition as predicted. No significant associations were found among prior training, prior work experience, or learning style and the acquisition of skills. The regression analyses of the FTAE overall scale, the conceptual scale and the therapeutic scale were significant, however the only significant predictor variable was the level of initial knowledge of family therapy.

CHAPTER V
DISCUSSION

The purpose of this study was twofold. First, the impact of the initial phase of family therapy training on novice therapist's skill acquisition was assessed. Second, the impact of four types of trainee characteristics on the acquisition of family therapy skills by novice therapists involved in family therapy training was examined. The four types of trainee characteristics were (a) extent of trainee's prior training in individual therapy and family therapy, (b) extent of trainee's clinical work experience in individual therapy and family therapy, (c) extent of initial family therapy knowledge, and (d) trainee's preferred learning style. In this chapter, a discussion of the results for each of the research questions or hypotheses, the limitations of the study, and implications of the study are presented.

Preliminary Analysis

Prior to testing the research hypotheses proposed for the study, an analysis of covariance (ANCOVA) was performed to assess whether the subjects from each of the six participating programs differed significantly in their skill acquisition from pretesting to posttesting. The

Family Therapy Assessment Exercise (FTAE) pretest and posttest scores of students from each of the six participating schools were analyzed using an ANCOVA. Results of this analysis revealed a significant difference by school. Dunn's test revealed that one of the six schools differed significantly from the other five. On the adjusted posttest this school was deleted from the study sample in order to allow for program equivalency and equivalent program effects. There are various explanations that could contribute to the differences by school, such as instructor differences or course content differences, although measures were taken to provide some type of equivalency. In addition, the FTAE measures structural/ strategic family therapy, perhaps competing ideologies were more pronounced for this portion of the sample. A second ANCOVA was conducted on student scores for the five remaining schools. No significant differences were found among the five remaining schools, thus the remaining five schools were considered as one construct.

Discussion of Results

The first question considered in this study concerned how trainees in the initial stage of training in university-based family therapy programs could be characterized in terms of their (a) age, (b) prior training experience in individual therapy, (c) prior work experience in individual therapy, (d) prior training in marriage and

family therapy, (e) prior work experience in marriage and family therapy, (f) initial knowledge of family therapy knowledge, and (g) preferred learning style.

The average age of this sample of trainees was 32.98 with a range of 28 to 60 years. Almost 50% of the students were under the age of 30, with only a small number of the trainees falling in the upper age range. Thus, this sample can be characterized as a predominately young group of trainees.

The average number of courses taken in individual counseling was 7.69, with the average number of family therapy courses taken .74. Supervision hours in individual counseling averaged 30.32, with supervision hours in marriage and family therapy averaging 5.33. The amount of work experience in individual counseling averaged 1½ years, with marriage and family therapy averaging ¼ year. Clearly the amount of training in individual counseling and particularly in marriage and family therapy was very limited. Based on a semester system this would place trainees in their first year of training in individual counseling. Family training was extremely limited (less than one course, 5.33 hours of supervision, and ¼ years work experience). Thus this sample can be characterized as novice-level trainees in both individual counseling and in marriage and family therapy which uniquely differentiates them from other study samples. In contrast, samples used

in other studies conducted by Hernandez (1985), Pulleyblank (1985), Breunlin et al. (1989) were drawn from a cross range of novice, mid-range, and experienced therapists. For example, in an instrument validation study, Hernandez (1985) studied 75 subjects drawn from university and institute programs located in Illinois and Indiana. Their age ranged from 22 to 60 years and participants were characterized as novice-level, mid-range, and experienced therapists. The sample included first year master's level students, doctoral students, post-doctoral students, university professors, and AAMFT approved supervisors.

Pulleyblank (1985) evaluated a 9-month structural family therapy training program. Nine family therapy trainees and eight control subjects were evaluated before and after the training program. All trainees held a master's degree in either marriage and family therapy or social work with a mean number of years of work experience after their degree of 5-7 years. The comparison group's average age was 31.2. All comparison group members held a master's degree in marriage and family therapy with a mean number of years of work experience of 3.6 after their degree.

Breunlin et al. (1989) examined skill acquisition of 96 trainees drawn from seven different structural/strategic training experiences. Four of the programs involved agency based inservice training in family therapy, two involved

graduate courses in family therapy (one in nursing and one in social work), and one program was an advanced training program in family therapy. Subjects ranged in experience from those with little clinical experience or training in family therapy to those with considerable clinical experience and training in family therapy. The field of family therapy is diverse. Practitioners may have an M.D., Ph.D, M.S.W., M.A. or M.S. degree and still practice family therapy, which itself is not always clearly defined. Family therapy requires different conceptual and therapeutic skills, than individual therapy. This study focused on beginning level family therapy trainees enrolled in master's level university based training programs which differs from samples used in previous studies.

The extent of prior knowledge of family therapy was assessed by computing pretest scores for the Family Therapy Assessment Exercise (FTAE) for each participant. The average score for the entire group was 12.9 with a possible score of 32. This is similar to initial knowledge pretest scores reported in previous research (Hernandez, 1985; Pulleyblank, 1985). For example, in a validation study for the FTAE conducted by Hernandez (1985), FTAE scores averaged 14.64, based on 32 questions. In a program evaluation study reported by Pulleyblank (1985), the FTAE pretest score averaged 16.58 for the treatment group of trainees receiving post-master's level training at a family

therapy training institute, and 13.60 for the comparison group used in the study. Breunlin et al. (1989) noted that initial knowledge (IK) of the trainee as measured by the Family Therapy Assessment Exercise (FTAE) pretest score was inversely correlated with the change score. However, the authors did not report raw scores for the FTAE. The average pretest score for this group in the study was 12.9 which was slightly less than scores reported in other studies (14.64, 16.58, 13.60). However, that is logical because this group is predominantly a novice level group versus a cross section of novice, mid-range, and experienced family therapists who may have had exposure to family therapy theory and practice.

Finally, the preferred learning style of the trainee was assessed with four possible categories resulting. Trainees clustered as follows: 51.6% (51) of the participants were divergers, 13.1% (13) were convergers, 17.1% (17) were accommodators, and 20.2% (20) were assimilators. More than half of the participants described themselves as divergers which was consistent with the learning style research in this area. For example, Kolb (1976), in examining the relationship between learning style and academic specialization, found a strong association between the divergent learning style and counseling and psychology career specialization. Previous research studies on learning style and professional career

choice (Bennett, 1978; Christensen & Bugg, 1979; Kolb, 1978; Plovnick, 1974; Sims, 1980) are also consistent with this finding.

Trainee Skill Changes

In hypothesis one the impact of the initial phase of structural/strategic family therapy on the acquisition of skills by novice student therapists was examined. Significant differences from pretesting to posttesting were found in the study participants scores on the FTAE overall scale and the descriptive, conceptual, and therapeutic subscales. This was not an unexpected finding and was consistent with the findings reported in previous research (Breunlin et al., 1989; Pulleyblank & Shapiro, 1986; West et al., 1985). However, the initial levels of family therapy skills and the final level of skills of this group were lower than that of other research assessing skills of more experienced therapists.

For example, West et al. (1985) examined 10 mixed experience level family therapy students enrolled in a graduate level course in family therapy in which students practiced interviewing simulated families. A time series design was used whereby skill development was assessed at three equal intervals of time during the semester. The FTAE was used to measure skill development. A repeated measures analysis indicated there were significant differences between testing times on the total score.

However, regarding subscales, significant differences were found from time 1 to time 3 with combined scores for observational and conceptual subtests, while conceptual skills increased significantly from time 1 to time 2, and observational skills significantly increased from time 2 to time 3. No significant differences were found for the therapeutic subtest. The method of training used in this study emphasized conceptual and observational skills which may account for the significant change in these scores. In addition, the authors suggested that sequencing in learning may be a factor, where novice level students acquire conceptual skills followed by observational skills.

In contrast, the findings in the present study suggest that a significant change occurred for the overall scale and all three subscales, with the conceptual and therapeutic subscales increasing most significantly. Perhaps skills changes in novice trainees may differ from those of mixed experience levels. A time series design which measures minute skill changes in trainees or even one that is longitudinal in nature may be of interest in developing curriculum that attends to subtle developmental stages. Further research is needed to determine patterns of skill acquisition. In conjunction with conducting the regression analyses, intercorrelation among trainee variables were computed.

Intercorrelations

Intercorrelations among trainee variables were predictable. For example, marriage and family therapy work experience was significantly correlated with individual work experience, supervision in both individual counseling and marriage and family therapy, and coursework in individual counseling. Clearly, this was not surprising because both training and supervision are prerequisites for work experience. Interestingly, no significant correlations were found with coursework in marriage and family therapy. Perhaps this was due to the limited amount of marriage and family therapy coursework obtained, by this sample of trainees (less than one course).

Correlations among selected personal characteristics of the trainee and the Family Therapy Assessment Exercise (FTAE) and its three subscales were also limited. Interestingly, the pre-FTAE overall scale and three subscales were negatively correlated with the change score. As previously noted, this supports the hypothesis that the greater the amount of initial knowledge of the trainee, the less the amount of change from pretesting to posttesting on the Family Therapy Assessment Exercise (FTAE). However this may also be explained in terms of the regression effect in that higher scores regress towards the mean while lower scores go up towards the mean.

In hypotheses two through seven the associations between a variety of demographic and background variables and family therapy skill changes of the trainee were examined. Specifically, the following independent variables were explored: initial level of family therapy knowledge, previous individual counseling training and work experience, previous family therapy training and work experience, and preferred learning style. As predicted, the higher the initial knowledge level of family therapy, the smaller the skill changes noted from pretesting to posttesting. As previously mentioned this can also be explained in terms of the regression effect. Interestingly, none of the other trainee variables proved to be significantly associated with family therapy skill changes. Furthermore, it was surprising that none of these variables was significantly correlated with initial knowledge of family therapy given the assumption that prior training and work experience and initial knowledge would be strongly associated. Obviously, in this sample initial knowledge was not a result of prior training and work experience.

These findings are not consistent with results reported by Breunlin et al. (1989) who found, using a sample of varying experience levels that experience in individual therapy was significantly associated with increased family therapy skills as measured by the Family

Therapy Assessment Exercise (FTAE). Not only was prior individual therapy experience positively associated with performance on the FTAE overall scale but the conceptual score as well. Because the sample used in the present study were novice level they differed significantly in individual counseling and marriage and family therapy training and work experience (averaging 1½ years of individual work experience and ¼ year of marriage and family therapy work experience). In addition, those few trainees who did report a considerable amount of work experience in individual counseling were often helping professionals who had work which involved a very limited amount of direct clinical experience. Therefore, both the nature and extent of individual therapy work experience in this sample differed considerably from that of other study samples.

In hypothesis seven, no significant relationship was found between the learning style of the trainee and the amount of change from pretesting to posttesting in family therapy skill level as measured by the Family Therapy Assessment Exercise (FTAE). It is certainly possible that there is no relationship between learning style and family therapy skill development. However, one explanation for this may be a lack of sensitivity of the Learning Style Inventory. Interestingly, 50% of the participants classified themselves as divergent learners; however, a

wide variability existed in scores, with some divergers obtaining scores that were more balanced in terms of other learning styles verses extreme. A second explanation is that learning style may be more crucial over time as the trainee shifts from the conceptual to the applied focus. A third very plausible explanation is that the acquisition of family therapy skills is independent of learning style and something trainees learn equally well. Thus, the training experience gives something equally to all participants. Therefore, although learning style does not predict acquisition of skills this finding can be encouraging in that it may reveal that no bias exists in the training program.

Limitations of the Study

Descriptive studies, such as this one, must be interpreted with caution for a number of reasons. First, because the design of the study did not address the complete time frame of the training experience, distinctive patterns of change in the relationships among skills acquired and trainee characteristics were not assessed. It may be that the particular impact of a trainee's preferred learning style on the therapy learning process may be demonstrated only as therapy skill acquisition moves from a conceptual to applied framework.

Second, there are some inherent limitations in the study sample due to the selection procedure used wherein

only those programs who agreed to participate in the study and allowed access were sampled. This resulted in a mixed selection procedure employing both the inclusion of entire available populations and the voluntary invitation of students in those populations to participate. Despite the fact that this resulted in a relatively high proportion of students participants (92%), not all students invited to participate in the study did so. In addition, it is not known how many of these classes and students actually fit the criteria for inclusion. Thus, a sampling bias due to school and self selection may have been present. Perhaps those who chose to respond to the survey were the most skilled and confident members of the sample while those who did not were too unsure of their skills to respond. It was evident that selection occurred at the institutional level and that only those institutions with relatively high levels of intellectual rigor were chosen to participate. Conceivably, academic settings which differ substantially from these settings in academic standards and climate may attract students who differ markedly in terms of their personal characteristics and abilities. Thus these results may not be generalizable to students involved in substantially different academic training contexts.

The data revealed that the test for between school differences was almost significant ($p=.06$) which indicates the probability of school effects. A design in which

school is considered as a factor in the analysis and subjects are nested within school may be desirable for future research projects. However, a much larger sample of schools would be required in order to conduct this type of analysis.

The instruments used in this study posed a third limitation. Only one method of measurement was used in the study to measure skill acquisition. Clearly multiple methods of measurement would cross validate measurement of skill acquisition. However, the particular instrument chosen to assess skill development was considered the best available method, despite weaknesses in reliability and validity of the subscales. In addition, measurement of the learning style variable may need to be improved. Although the learning style theory itself appears to have a great deal of merit, it may be beneficial to look more closely at the particular learning style instrument in terms of its conceptualization and discriminant validity.

For example, this particular instrument measured narrowness of learning style versus diversity, yet the construct presented the conceptualization that a broad cognitive style was preferred to a more exclusive mode of learning. Therefore, another approach to measuring learning style as well as multiple methods of measurement of family skills may be more desirable.

Implications

This study has implications in several areas. There are implications for the status of the literature and for the direction of future outcome research on family therapy training. Examining the type of skill development of novice therapists during the initial stages of family therapy training can be useful in the ongoing refinement of family therapy training experiences in academic contexts. Moreover, ascertaining which trainee variables are vital to consider in predicting learning among younger professionals can be helpful in shaping both selection and training design decisions and policies.

Variables such as maturity, past life experiences, and prior training and work experience are commonly used predictor variables for trainee candidates. However results of this study do not support the use of prior training and work experience as predicative criteria for the novice-level therapist. Clearly, the amount of prior training and work experience was very limited which may account for this lack of predictive power.

Traditionally, professionals involved in providing psychotherapy training have had difficulty in defining what skills or aptitudes are relevant predictive factors for performance as therapy professionals. While Graduate Record Examination scores and college grade point averages are of value in predicting graduate student academic

performance, there have been no established indices for predicting student clinical skill performance. Kolb's (1978, 1981, 1984) theory of experiential learning was used in this study to identify a trainee's preferred learning mode and focus on how it may facilitate or hinder acquisition of skills. Results of this study do not support the use of learning style as predictive criteria for the acquisition of family therapy skills for novice level trainees. A plausible explanation for this finding is that preferred learning style does not influence the acquisition of family therapy skills, and novice-level trainees learn equally well from the training experience. In another vein, possible avenues for future study in this area of learning style research include (a) assessing learning style differently, (b) the use of a longer time frame to assess training, and (c) obtaining a broader sample representation of training and work experience.

Finally, the initial knowledge of family therapy as measured by the Family Therapy Assessment Exercise (FTAE) did significantly predict acquisition of family therapy skills. As previously mentioned, this may be due to the regression effect. However, it was of interest that the level of initial knowledge did not significantly correlate with previous training and work experience variables. Perhaps cognitive factors contribute to the level of initial knowledge and may be a useful direction for future

research studies. Clearly the examination of skill acquisition of family therapy trainees has implications not only for training but for the practice of family therapy as well.

Summary

In conclusion, this researcher has described the nature/characteristics of the novice-level trainee; assessed the skill acquisition of novice-level trainees in the initial phase of family therapy training; and investigated the impact of four trainee characteristics: (a) extent of prior training in individual and family therapy, (b) extent of prior work experience in individual and family therapy, (c) extent of initial knowledge of family therapy, and (d) preferred learning style of the trainee. Results have been interpreted to indicate that the initial phase of family therapy training does significantly improve the novice-level trainee's skill acquisition. Initial knowledge of family therapy did affect the amount of skill acquisition of student therapists in an inverse direction. However, trainee characteristics such as prior training, work experience and learning style did not influence the acquisition of family therapy skills. It was not surprising that prior training and work experience had no predictive power because of the limited amount accrued by trainees. However, it was

somewhat perplexing that learning style had no predictive power.

Results showed that more than 50% of the trainees characterized themselves as divergent learners which correlates with previous learning style research. A possible explanation for the lack of predictive correlations was limitations of the instrument. The scoring of the instrument emphasized narrowness of learning style verses diversity. In addition trainees were examined at one point in time as opposed to over a period of time. Perhaps, a more distinctive pattern would appear over time or with a more diverse sample of trainees. Another possible explanation is that learning style does not influence that acquisition of family therapy skills and thus students learn equally well.

A need for additional research in the area is indicated by the results of this study. Characteristics traditionally used to predict skill acquisition of trainees had little predictive power for this novice-level group. Characteristics which have some predictive power with this particular group would be helpful for selection and placement of beginning therapists. This is a useful undertaking because of the trend towards educating younger master's level family therapists versus post-degree training of family therapists.

APPENDIX A
INFORMATION TO PARTICIPATING UNIVERSITIES

Letter of Introduction to University Professors

Dear Professor:

As you may recall from our telephone conversation, I am currently doing my dissertation study in the area of marriage and family therapy training. I am interested in studying the impact of individual trainee characteristics, such as learning style, on the acquisition of family therapy skills. The study is a pretest-posttest design which would require student participants to answer questionnaires and view a videotape at the beginning and end of the course.

I have enclosed the following materials for the class:

1. Class Announcement - to be read by the instructor

2. Release of Information - to be signed by participants

3. Demographic Questionnaires: (a) pretest and (b) posttest - to be completed by participants

4. Kolb Learning Styles Inventory (LSI) (Instructions are self-explanatory) - to be completed by the participants at pretest only

5. Family Therapy Assessment Exercise (FTAE) Tape - to be shown to class by the professor/instructor at pretesting and posttesting

6. Family Therapy Assessment Exercise (FTAE) Instructions and Questionnaire (Instructions are self explanatory) - to be completed by the participants at pretesting and posttesting

7. Family Therapy Assessment Exercise (FTAE) Answer Sheets - (a) pretest (time 1) and (b) posttest (time 2)

In addition to this, in order to establish some commonality for the training experiences (course), I would like to obtain (a) a course syllabus and (b) a course description checklist from you. I have enclosed the course description checklist and a stamped return envelope for this and the course syllabus. I would greatly appreciate this information at your earliest convenience. Enclosed you will also find a stamped return packet for the participant materials pretest-posttest) which can be mailed at one time at the end of the semester.

I would like to take the opportunity to thank you in advance for your participation in the study and the time and effort you put forth. I will be contacting you by phone within the next few weeks as to the materials and any questions you may have concerning the study. If you have any questions, please feel free to call me at (407) 352-2769 (collect). Thank you again.

Sincerely,

Rita Lawler Goodman, M.S., Ed.S.

RLG/aw

Class Announcement

"We are interested in studying the training of family therapists and we need your help. Specifically we would like to examine performance of trainees at the beginning and end of this course to assess their ability to look at interactional patterns and ways of working with families. Participation in the project requires you to view a videotape of a simulated family therapy interview. The tape will be stopped intermittently so that multiple choice questions concerning each segment of the interview can be answered. In addition, you will be asked to complete two brief questionnaires regarding your personal learning style and your training and work experience in the field of counseling/psychology and marriage and family therapy.

Participation in this project is voluntary. The data collected for the project is not part of the class requirement, will in no way affect your participation in the class, and will not be viewed by the instructor to determine your grade. Participation in the project will be scheduled during class time at the beginning and end of the semester. The project will address several questions regarding effective training of marriage and family therapists. We are aware that it would be of some benefit to you as a participant, therefore, we are willing to give you personal feedback concerning your participation at the end of the project.

All information will be kept strictly confidential. Please feel free to ask any questions that you may have concerning the project."

APPENDIX B
CLASS CONTENT CRITERIA

There are a wide variety of approaches used in training marriage and family therapists. The area of interest for this study concerns the examination of beginning students' acquisition of skills in structural/strategic marriage and family therapy. We have developed a list of instructional activities which are often used in the beginning phases of family therapy training.

Class Description

Generally, the beginning phases of marriage and family therapy training focus on theoretical concepts from one or some of the major theories of family therapy with an emphasis on assessment for treatment planning. Therapist skills in assessment, interviewing, and consultation are usually discussed and simulated.

Some commonly used instructional activities and methods are listed below. In addition, some typical reading resources are also listed. Please circle the items which approximate those you use in your approach.

1. Introduce systems-oriented patterns of conceptualization, assessment and therapy practice.

2. Review systems and family development concepts.

3. Describe levels of family interaction assessed from various schools of family therapy with some emphasis placed on structural/strategic family therapy.

4. Describe family assessment criteria (e.g., structural boundaries, hierarchy, strengths, resources).

5. Describe pre-interview assessment planning.

6. Describe assessment interview skills.

7. Illustrate how to assess family patterns by mapping a family (video or simulated) from a) developmental view, b) structural view, and c) interactional sequence view.

8. Formulate an initial hypothesis of a family from the initial intake/face sheet using appropriate assessment criteria.

9. Analyze written and videotaped interactional segments.

10. Make an assessment of a family through the analysis of a videotape presentation or simulation.

11. Participate in role playing of an initial family assessment interview.

12. Conduct an assessment/consultation interview with a simulated family or couple.

13. Use of written examinations to evaluate informational level.

14. Interview a simulated family and write up a family assessment summary and treatment recommendations.

15. Write a major paper evaluating a family from a particular conceptual viewpoint.

Please add items not mentioned which you use in your course.

_____

_____

_____

Readings: Please circle those readings listed below which you use in your course:

1. Aponte, H. J., & Van Deusen, J. M. (1981). Structural family therapy. In A. S. Gurman & D. P. Kniskern (Ed.S.) Handbook of Family Therapy (pp. 310-360). New York:Brunner/Mazel.

2. Beavers, W. R. (1977). Psychotherapy and growth: A family systems perspective. New York: Brunner/Mazel.

3. Carter, E. A., & McGoldrick, J. (1980). The family life cycle. New York: Gardner Press.

4. Constantine, L. (1986). Family paradigms: The practice of theory in family therapy. New York: Guilford Press.

5. Fisch, J., Weakland, J., & Segal, L. (1982). The tactics of change. San Francisco: Jossey-Bass.

6. Haley, J. (1976). Problem-solving therapy. San Francisco: Jossey-Bass.

7. Madanes, C. (1981). Strategic family therapy. San Francisco: Jossey-Bass.

8. Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.

9. Minuchin, S., & Fishman, H. C. (1981). Family therapy techniques. Cambridge, MA: Harvard University Press.

10. Nichols, M. (1984). Family therapy: Concepts and methods. New York: Gardner Press.

Other_____

_____

_____

APPENDIX C
INFORMED CONSENT FOR FAMILY THERAPY PROJECT

We are interested in studying the impact of family therapy training and we need your help. Specifically, we would like approximately 3 1/2 hours of your time. Two hours at the beginning of the semester and 1 1/2 hours at the end. During this time you will be asked to view a videotape of a simulated family therapy interview. The tape will be stopped intermittently so that multiple choice questions concerning each segment of the interview can be answered. In addition, you will be asked to complete two brief questionnaires regarding your personal learning style and your prior experience in the general field of counseling and the specialty of marriage and family counseling.

Participation will be scheduled at your convenience.

The project will address several questions regarding effectiveness of training in family therapy. We are also aware that it should have some personal meaning of benefit to you as a participant. Therefore, we would be very willing to give you personal feedback concerning your participation at the end of the project.

Participants' names will be coded by number. Although the instructor will administer the questionnaires, all scoring and feedback of test results will be handled by the researcher. Therefore, the instructor will have no knowledge of an individual's performance. Please feel free to ask any questions that you may have.

I understand the nature of the research described to me above and I agree to participate with the knowledge that I may withdraw any time without prejudice.

_____
Signature of Participant

_____
Rita Lawler Goodman, M.S., Ed.S.
Principal Investigator

_____
Ellen Amatea, Ph.D.
Supervisor

APPENDIX D
THERAPY EXPERIENCE INVENTORY

Background Information

Please complete the following questions about yourself, your training, your work experience and your counseling/ therapy orientation.

1. Name _____

2. Age _____ 3. Race _____ 4. Sex: M F

5. Marital status (circle one)
Never married; married; divorced; separated; remarried; cohabiting

6. Ages of children (if any) _____
(indicate if natural or stepchildren)

Training

7. What academic degree(s) do you now hold and in what field(s) of study? _____

8. Are you currently enrolled in a degree program? _____ If so, please specify the degree and the major/tract you are in. _____

9. Is the GRE a requirement for this program? _____ If so, what is your GRE score? _____

10. What year are you in this program? (e.g., first year, fourth year) _____

11. Approximately how many courses have you had on counseling/psycho-therapy? _____ What percentage of these have focused on family/systemic counseling/ therapy? _____

12. Approximately how many hours of one-on-one supervision of your counseling/psychotherapy have you received? _____ What percentage of these hours were devoted to family counseling/therapy supervision?_____
Was your family counseling/therapy supervisor a trained family therapist? _____ If so, what was his/her orientation? _____

13. Do you currently receive family therapy supervision? _____ If so, specify the number of hours per week and type of supervision (e.g., live, video, audio, case) _____

14. Approximately how many hours of workshop/continuing education training on family therapy counseling have you participated in over the past 5 years?_____

Experience

15. How many years of experience (use fraction if less than one) would you say you have in doing INDIVIDUAL (i.e., not family counseling/therapy)? _____ What percentage of this was direct service (face-to-face client contact)? _____
Approximately how many individuals have you worked with in counseling/therapy? 1-3 ___ 4-10 ___ 11-25 ___ 26-50 ___ more than 50 ___

16. How many years of experience (use fraction if less than one) would you say you have in doing FAMILY counseling/therapy? _____ What percentage of this was direct service (face-to-face client contact)? _____
Approximately how many families have you worked with in family therapy?
1-3 ___ 4-10 ___ 11-25 ___ 26-50 ___ more than 50 ___

17. Approximately how many contact hours have you accumulated in doing counseling/therapy? _____

18. Approximately how many contact hours have you accumulated in doing family? _____

19. Please indicate the predominant type of counseling/psychotherapy you have been doing and the proportion of your time involved by circling one of the following:
    a. individually oriented counseling only
    b. mainly individual, but some family (please give percentage of usual work load that is individual _____ and percentage that is family _____)
    c. mainly family, but some individual (please give percentage of usual work load that is family _____ and percentage that is individual _____)
    d. family only
    e. other (please specify)_____

Background Information at Time 2

NAME _____

Since you participated in this assessment at the first of the term how much further training and work experience in individual and family systems counseling/therapy have you acquired?

Please list the number of counseling contact hours you have accumulated during this term.

Family counseling contact hours _____
Individual counseling contact hours _____

Please list any supervision (individual or group supervision) which you have acquired this term.

Family therapy supervision:
One-to-one supervision _____
Group supervision _____

Individual therapy supervision:
One-to-one supervision _____
Group supervision _____

Please describe any additional family systems related coursework or workshops in which you have participated since the assessment at the first of the term (other than this course).

_____ Classes (hours)
_____ Workshops (C.E.U.'s)

Any other experiences we should know about?

APPENDIX E
KOLB LEARNING STYLE INVENTORY

Name_____ Date_____

There are nine sets of four words listed below. Rank order the words in each set by assigning a 4 to the word which best characterizes your learning style, a 3 to the word which next best characterizes your learning style, a 2 to the next most characteristic word, and a 1 to the word which is least characteristic of you as a learner.

You may find it hard to choose the words that best characterize your learning style. Nevertheless, keep in mind that there are not right or wrong answers – all the choice are equally acceptable. The aim of the inventory is to describe how you learn, not to evaluate your learning ability.

Be sure to assign a different rank number to each of the four words in each set; do not make ties.

1.	___discriminating	___tentative	___involved	___practical
2.	___receptive	___relevant	___analytical	___impartial
3.	___feeling	___watching	___thinking	___doing
4.	___accepting	___risk-taker	___evaluative	___aware
5.	___intuitive	___productive	___logical	___questioning
6.	___abstract	___observing	___concrete	___active
7.	___present-oriented	___reflecting	___future-oriented	___pragmatic
8.	___experience	___observation	___conceptualization	___experimentation
9.	___intense	___reserved	___rational	___responsible

Scoring

The four columns of words above correspond to the four learning style scales: CE, RO, AC and AE. To compute your scale scores, write your rank numbers in the boxes below only for the designated items. For example, in the third column (AC), you would fill in the rank numbers you have assigned to items 2, 3, 4, 5, 8, and 9. Compute your scale scores by adding the rank numbers fo reach set of boxes.

Score items: 2 3 4 5 7 8	Score items: 1 3 6 7 8 9	Score items: 2 3 4 5 8 9	Score items: 1 3 6 7 8 9
CE = _____	RO= _____	AC = _____	AE = _____

To compute the two combination scores, subtract CE from AC and subtract RO from AE. Preserve negative signs if they appear.

AC-CE: [AC] - [CE] = _____ AE-RO: [AE] - [RO] = _____

APPENDIX F
THE FAMILY THERAPY ASSESSMENT EXERCISE

Instructions for Assessment Exercise

Introduction

You are about to take part in an exercise in which you will see a series of video tape segments from one family interview and after each segment answer several questions about the interview. The exercise is designed to assess the framework you employ when you deal with families. In this sense it is not intended to be a measure of your competence so much as a measure of how you work. You should, therefore, select the alternative for each question which best fits your way of working with families now, and not an alternative you suspect might be correct for other reasons. If you have never interviewed a family, then select the alternative which most closely fits how you imagine you would work.

You will be asked to answer questions relating to your observations, your ways of thinking about the family and your assessment of the therapist. To answer the observational questions you must attend closely to all behaviors (both verbal and nonverbal). When answering

questions concerning your understanding of events, remember that all of the alternatives have some validity depending on one's perspective so select the ones which seems correct to you. You will also answer questions regarding your assessment of the therapist. Some of the therapist's interventions should be considered mistakes so do not hesitate to select alternatives which are critical to the therapist.

Format for Exercise

The events portrayed on the tape are from one interview. The eight segments you will see provide you with the salient information to follow that interview. After you see the first segment of the interview, turn the page and begin to answer questions. Continue answering questions until you see the word STOP at the bottom of the page. At this point, do not turn the page until you have seen the next segment of tape. Continue in this manner until you have seen all eight segments. You will answer 32 questions. While you are answering questions, the tape will continue to run, showing only "grey" on the screen; hence you have a limited time to answer the question. The time available for each segment is shown at the top of the first page of questions for each segment. You will hear a tone twenty seconds before a new segment appears on the screen. Do not attempt to answer questions while a segment is being shown as you may miss valuable

information, and do not go back to change answers once a new segment is shown. The total time for the exercise is approximately one hour.

The Family

The Davidson family consists of four members; the parents, Robert and Marie, and two children, Susie, 10 and Carl, 9. The therapist is Dr. Brown. Recently, Mrs. Davidson brought Carl to Dr. Brown because he was wetting the bed. Carl received a complete workup and the tests were normal. Recognizing that Carl appeared to be highly anxious, and that multiple factors might be involved in such a case, Dr. Brown requested the entire family to come into this office to discuss the problem at length. The present videotape is performed by actors to preserve the confidentiality of the family. However, this is not a dramatization, as the original transcript is followed closely. The adaptation, including the choice of segments, is geared to abbreviate and highlight material for training purposes.

STOP

DO NOT TURN THE PAGE UNTIL YOU HAVE SEEN THE FIRST SEGMENT OF TAPE

QUESTIONS FOR SEGMENT ONE

You Have 7:00 To Answer

1. Select the alternative which describes most accurately what is happening when Susie first begins to fidget with her hat.

   a. The therapist is talking to father.

   b. The therapist is talking to mother.

   c. The therapist is talking to Carl.

   d. The therapist is talking to Susie.

2. Below is a list of six statements all of which are true of the family members' behavior before the therapist entered. Select one of the four alternatives that groups together the three statements that best help you to understand the presenting problem.

   1. The parents do not attend to the children's play.

   2. The children ignore mother's request to put the toys away.

   3. The parents make no attempt to reinforce appropriate behavior in their children.

   4. Father yells at the children to put the toys away.

   5. Mother defends the children's behavior to father.

   6. The parents demand rather than request that the children put away the toys.

      a. 1, 2, 4

      b. 1, 3, 6

      c. 2, 4, 6

      d. 2, 4, 5

CONTINUE TO THE NEXT PAGE

3. Given the information concerning the family members' behavior before the therapist entered, which of the following content areas would be closest to your focus for the upcoming interview.

   a. The way father was treated by his own parents.

   b. What prevents the father, mother and children from expressing their feeling directly.

   c. How the father and mother handle demands they make on the children.

   d. Why the father needs to displace his anger on to the children.

4. Select the alternative which you believe is the least accurate assessment of the therapist's greeting of the family members.

   a. By speaking to Carl least the therapist acknowledged Carl's embarrassment for being the identified patient with a sensitive problem.

   b. The therapist should have spoken more to Carl because he too must be engaged and motivated.

   c. The therapist should have further explored the father's work in order to highlight it as an area of competence for the father.

   d. The therapist missed an opportunity to focus on interaction when Carl turned and whispered something to mother.

STOP

DO NOT TURN THE PAGE UNTIL YOU

HAVE SEEN THE NEXT SEGMENT OF TAPE

QUESTIONS FOR SEGMENT TWO

You Have 3:30 To Answer

5. Select the alternative which describes the content area being discussed when the father first cues the mother to speak for him.

   a. The number of times Carl has wet the bed in the past two weeks.

   b. The problems Carl has been having at school.

   c. The mother's work and the fact that she has taken some time off.

   d. The father doesn't cue the mother at all; she interrupts him.

6. Select the alternative which is the most useful conclusion the therapist could draw from the parents' speculations about the possible causes of Carl's bedwetting:

   a. The inability to agree on this issue is reflective of the general lack of agreement in their relationship.

   b. Because the parents do not ask for Carl's opinion on this issue, they probably disregard his feelings too much.

   c. Although the parents mentioned explanations which involved them, they preferred those which absolved them of responsibility for Carl's problem.

   d. The parents have considered explanations that involve themselves which is a good sign.

CONTINUE TO THE NEXT PAGE

7. In this segment, the therapist asks father to describe the problem first, before Carl or mother. Select the alternative which you believe is the best assessment of this intervention.

   a. The intervention is a mistake because had he asked Carl first he would have learned something of his feelings unbiased by the opinions of his parents.

   b. The intervention is correct because it initiates the process of defining the father as an important person in the family.

   c. The intervention is a mistake because had he asked to the mother first he would have supported the parent likely to be most involved in the problem.

   d. The intervention is a mistake because by asking the father to speak first, the therapist loses an opportunity to find out who the spokesperson for the family is.

8. In this segment, the therapist asks several questions related to the parents' suggestion that Carl's bedwetting is somehow associated with worry. Select the alternative which you believe is the best assessment of this intervention.

   a. The intervention is correct because it provides an explanation which enables the therapist to focus on family interaction.

   b. The intervention is a mistake because he fails to ask Carl whether he actually worries about such things.

   c. The intervention is a mistake because he is beginning to show the connection between Carl's bedwetting and his feelings.

   d. The intervention is a mistake because he prematurely leads the parents to view Carl's problem in a certain way.

STOP

DO NOT TURN THE PAGE UNTIL YOU

HAVE SEEN THE NEXT SEGMENT OF TAPE

QUESTIONS FOR SEGMENT THREE

You Have 5:30 To Answer

9. At one point in the segment you just observed the father defends himself and then criticizes the mother. To answer, select the alternative which best describes what happens just <u>after</u> this occurs.

   a. The mother again criticizes the father.

   b. Carl defends his mother.

   c. Father criticizes Carl.

   d. The mother asks Carl a question.

10. Select the alternative that is closest to what you think would be best to say at this point.

   a. Carl, how are you feeling right now?

   b. Mr. D. I would like for you and Carl to try to talk to each other in a different way right now. Are you willing to try?

   c. Mr. D. the issue was originally between you and your wife. Can you get her to talk to you about discipline without either of you drawing Carl into the discussion?

   d. Is this typical of what happens at home, where Carl fights with his father so his mother does not have to?

CONTINUE TO THE NEXT PAGE

11. Select the alternative which you believe is the best explanation to account for father yelling at Carl.

    a. Father is taking out the anger he feels toward his wife on Carl.

    b. Father yells at Carl, and thus avoids further conflict with mother.

    c. Father has a bad temper which easily gets out of hand.

    d. Father is extremely sensitive about the subject of discipline.

12. Select the alternative which you believe is the best explanation for the style of father's discipline.

    a. The style is related to his wife being too soft in her discipline.

    b. The style is related to the anger he feels toward his wife.

    c. The style is related to his inability to tolerate behavior in his children of which he does not approve.

    d. The style is related to the frustration he experiences when his children are repeatedly disobedient.

STOP

DO NOT TURN THE PAGE UNTIL YOU

HAVE SEEN THE NEXT SEGMENT OF TAPE

QUESTIONS FOR SEGMENT FOUR

You Have 5:00 To Answer

13. Select the alternative that is closest to what you think would be best to say at this point.

    a. Mrs. Davidson, you and Carl are so close that it seems he can get you to speak for him. How does he get you to do this work for him?

    b. Carl is having trouble telling us how he feels. I wonder what this is about, and how we can help him feel more comfortable.

    c. Mrs. D., do you always let Carl win disagreements you have with him.

    d. Carl, I'm interested in what you have to say. There are no wrong answers here. Please tell me yourself.

14. Select the alternative which, in your opinion, best describes the interaction between Carl and the mother which takes place after the therapist moves to speak to the children.

    a. The interaction is an example of how the mother cannot control her son.

    b. The interaction is an example of how Carl's insecurity leads him to seek his mother's help.

    c. The interaction is an example of a general inability to reach agreement in this family.

    d. The interaction is an example of mother's involvement which Carl elicits.

CONTINUE TO THE NEXT PAGE

15. During this segment the therapist makes initial statements about the problem of discipline and gets the parents to discuss the issue. Select the alternative that best assesses this intervention.

    a. The therapist's initial statements excused the father's harshness to the point that the mother felt he took father's side and so she resists this information.

    b. The therapist created a good perspective with the parents about their discipline style, but did not follow through to get the family to interact in new ways based on this perspective.

    c. The therapist's initial statements were well formulated and helped set up the ensuing discussion. He was wise to not push the issue of discipline style further at this early stage of treatment.

    d. The therapist's initial statements were formulated on insufficient information, consequently he will have trouble getting the parents to accept these new ideas and try the new behaviors.

STOP

DO NOT TURN THE PAGE UNTIL YOU

HAVE SEEN THE NEXT SEGMENT OF TAPE

QUESTIONS FOR SEGMENT FIVE

You Have 3:00 To Answer

16. Select the alternative which is closest to what you would think would be best to say when Carl says "I have that problem too."

    a. Well, we all have problems. What we want to do today is give everyone an opportunity to discuss the problems they may be having.

    b. Carl, what are some things you might lie about? What do you think will happen if you tell the truth?

    c. Carl, when I'm talking to your sister, you interrupt and answer for her. Susie, does he always help you answer questions? Why do you let him talk for you?

    d. How do you as parents handle the lying problem?

CONTINUE TO THE NEXT PAGE

17. Select the alternative that best rates the therapist's intervention when he told the mother how to deal with the fights between Carl and Susie.

    a. In keeping with his earlier theme the therapist was correct in encouraging mother to prevent the fights herself and not force father to discipline them later.

    b. The therapist should have been more clear about the kinds of punishments mother should use whenever they fight.

    c. The therapist should have made it more clear to both parents that intense fighting between children should not be tolerated.

    d. The therapist incorrectly encouraged mother to continue to interfere in the sibling fights, consequently the kids will not be able to resolve them on their own.

18. Based on the video tape segments you have observed thus far, select the alternative which you believe is <u>least useful</u> to you in the formulation of the problem.

    a. The parents allow Carl to share in discussions of adult concerns.

    b. Carl is involved in arguments between his parents.

    c. The father is harsh to Carl resulting in hostility in their relationship.

    d. The mother defends Carl from his father.

<u>STOP</u>

DO NOT TURN THE PAGE UNTIL YOU

HAVE SEEN THE NEXT SEGMENT OF TAPE

QUESTIONS FOR SEGMENT SIX

You Have 5:30 To Answer

19. Earlier in the interview you observed a sequence in which the conversation also begins with parents and then father berates Carl. Select the alternative which you believe is the best way to think about these two sequences.

a. The sequences should be considered essentially the same because the events and their order is essentially the same. In addition the outcome of both sequences is the same because further argument between mother and father is avoided.

b. The sequences should be considered essentially different because the issues discussed are different. The outcome is also different because in one father complains that Carl doesn't listen to mother, while in the other he and Carl argue about Susie.

c. Even though the events are nearly the same, the way Carl gets involved is different so the sequences are different. Nevertheless, the outcome is the same because father and Carl end up in an argument.

d. The sequences should be considered essentially the same because in both Carl is scapegoated.

CONTINUE TO THE NEXT PAGE

20. Select the alternative which you feel is the most useful way to view the sequence described in question 19.

    a. The father has a tendency to scapegoat Carl when he is angry with his wife.

    b. This family cannot tolerate sustained and overt conflict between the parents.

    c. This family has a low level of communication skills which hinders conflict resolution.

    d. When the father puts the mother down, she uses Carl to defend her.

21. Below are six statements about the therapist's behavior in the previous segment. Select the alternative which clusters together the three statements which you believe provides the best assessment of his behavior.

    1. Early in the segment he correctly redirected the topic from a marital to a parental issue that is more closely related to Carl's problem.

    2. He incorrectly redirects from marital issues because the parents should be encouraged to resolve those issues.

    3. The block of Carl would be improved by asking the mother to prevent Carl's interruptions.

    4. He correctly blocks Carl himself so that the parents do not get into a power struggle with Carl.

    5. At the end of the segment, the therapist incorrectly allows the father to avoid talking to his wife by engaging him.

    6. At the end, the father has accepted the therapist's intervention and the therapist is correct to engage with him to highlight the move.

        a. 1, 3, 5
        b. 2, 4, 5
        c. 2, 3, 6
        d. 1, 4, 6

CONTINUE TO THE NEXT PAGE

22. Select the alternative which corresponds most closely to what you as a therapist would do at this point in the interview.

    a. Explore with the family the reasons that they have chosen to include Carl in marital issues.

    b. Summarize and end the session at that point because they would leave remembering this intervention.

    c. Direct the father to talk directly to Carl about their relationship.

    d. Direct the parents to return to the issue they were discussing while continuing to block Carl.

STOP

DO NOT TURN THE PAGE UNTIL YOU

HAVE SEEN THE NEXT SEGMENT OF TAPE

QUESTIONS FOR SEGMENT SEVEN

You Have 5:00 To Answer

23. Select the alternative which is closest to what you think would be best to say when the mother turned to the therapist and said "How do we handle that, Doctor".

    a. I'd like to direct that question back to all of you. How do you think you can arrange family activities that please everyone?

    b. Mrs. Davidson, I can see that you want to be helpful, but your husband and son were doing a nice job of talking. Mr. Davidson, you talk with Carl about this.

    c. How do you think you can handle it, Mrs. Davidson.

    d. Mrs. D, I think you and your husband should sit down and discuss some ways of giving each child some time alone with each of you.

24. Using as background, the observations you have made about the relationship between father and Carl as depicted throughout the tape, select the alternative which, in your opinion, best assesses the conversation which took place between father and Carl in the last segment of tape.

    a. The conversation would have gone much better if the father didn't have a tendency to blame Carl.

    b. The conversation is representative of the way father and Carl usually talk.

    c. The conversation represents an improvement given father's role as "ogre" in the family.

    d. The conversation went as well as it did because mother stepped in to help on several occasions.

CONTINUE TO THE NEXT PAGE

25. Select the alternative which best describes what, if anything, you would have done when father and Carl were talking.

    a. When father began to lose his temper, I would have encouraged him to continue talking to Carl, and modeled a way that would make it easier for Carl to respond.

    b. When the mother first interrupted, I would have first praised her efforts to be helpful, and then told her that it was important that Carl and father talk by themselves.

    c. When Carl began to have trouble expressing himself, I would have asked him what he was feeling at that moment.

    d. Like the therapist, I would have said nothing throughout the conversation.

26. Suppose you were to select as a goal an improvement in the relationship between father and Carl. Select the alternative which comes closest to describing your next intervention to achieve this goal.

    a. Help the father and Carl understand that how they relate hurts each of them.

    b. Assist the father to behave less aggressively toward Carl and be more nurturing.

    c. Help Carl and father express their feelings toward one another.

    d. Keep the mother and Susie from interfering with the relationship between father and Carl.

STOP

DO NOT TURN THE PAGE UNTIL YOU

HAVE SEEN THE NEXT SEGMENT OF TAPE

QUESTIONS FOR SEGMENT EIGHT

You Have 4:00 To Answer

27. Which of the following most closely resembles your opinion about what happens in the conversation between Susie and her mother?

a. Susie suggested a way to improve the relationship but mother ignored it.

b. Mother made a suggestion but Susie rejected it.

c. Neither showed any real moves to improve their relationship.

d. Both made initiatives and both were dismissed by the other.

28. In the last segment of tape the father and therapist engage in conversations on several occasions. Select the alternative which you believe represents the outcome of these conversations.

a. The conversations support the father by building upon the work the therapist had done with him earlier in the session.

b. The conversations defocus the work involving mother and Susie.

c. The conversations help to define all members as part of the problem between mother and Susie, and encourage them to give their views about the problem.

d. The conversations make it easier for Susie and mother eventually to begin talking to one another.

CONTINUE TO THE NEXT PAGE

29. Which of the following is the least correct observation about the therapist's behavior in the last segment?

    a. The first time the father interrupts, the therapist nonverbally redirects the focus back to Susie and mother.

    b. After the second interruption the therapist made it clear that father and Carl should not interrupt mother and Susie.

    c. Early in the segment therapist makes it clear that it is important for mother and Susie to be able to talk to each other.

    d. At one point the therapist interrupts Carl's interrupting and redirects the focus back to mother and Susie's conversation.

30. In this segment mother and Susie have considerable difficulty talking to one another. Select the alternative which you believe provides the least useful explanation for this difficulty.

    a. Throughout the conversation, mother and Susie gave each other mixed verbal and nonverbal messages.

    b. Because mother has been very involved with Carl, and father with Susie, the relationship between mother and Susie is underdeveloped.

    c. The conversation was handicapped by repeated intrusions by father and Carl.

    d. At this early point in the therapy, Susie should not be expected to be disloyal to father by acting interested in the mother.

CONTINUE TO THE NEXT PAGE

31. Select the alternative which approximates most closely what you would have said when the mother turned to the therapist and said: "and I just kind of give up".

    a. It must be painful for both of you to have such difficulty talking to one another.

    b. Is that true Susie, are you really disinterested?

    c. You are doing a good job, and this isn't the time to give up. You are concerned about your relationship with Susie so encourage her to talk more with you.

    d. Susie did make a suggestion. How about acting on that suggestion.

32. Select the alternative which most closely describes the focus you would select for the next session.

    a. Work to shift the father-daughter and mother-son alliances.

    b. Work to help the family recognize that it is not just Carl who has a problem, but that they are all involved in the problem.

    c. Work to help the parents resolve their marital issues.

    d. Work to help the family understand the connection between Carl's emotions and his problem of enuresis.

END OF TEST

NAME: _____

DATE: _____

ANSWER SHEET

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NAME: _____

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ANSWER SHEET

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APPENDIX G
MEANS AND STANDARD DEVIATIONS OF TRAINEE CHARACTERISTICS, BY SCHOOL

Means and Standard Deviations of Trainee Characteristics, by School

	N=56		N=4		N=21		N=9		N=9	
	1		2		3		4		5	
Variable	M	SD	M	SD	M	SD	M	SD	M	SD
Age	31.4	8.40	28	2.70	39.14	10.21	31.89	6.39	30.50	6.04
Courses (Individual Counseling)	9.01	6.54	6.25	11.20	6.29	7.74	.67	.87	10.44	23.64
MF Courses	.55	.98	.75	1.50	1.04	1.20	.67	1.12	1.33	1.00
Supervision	24.66	56.28	0	0	69.71	202.67	0	0	17.44	27.98
MF Supervision	4.35	21.02	0	0	12.57	38.21	0	0	2.22	5.33
Ind. Years Exp.	1.53	2.22	.31	.37	2.04	2.97	.05	.16	2.27	2.50
MF Years Exp.	.34	1.18	0	0	.19	.46	0	0	.44	.58
ACCE	-.13	7.23	3.75	7.36	-1.38	6.94	-2.0	7.12	-1.11	5.55
AERO	2.17	6.40	9.00	2.58	-1.14	6.45	2.22	4.57	.11	5.11
LSIINT	.75	52.82	46.00	63.81	7.57	38.25	6.33	28.17	2.89	25.57
Extent of prior knowledge of Family Training Therapy	13.71	3.74	12.25	6.13	10.80	3.84	12.66	7.81	13.44	1.55

Years Experience:
.25 = ¼ year
1.00 = 1 year
12.00 - 12 years

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BIOGRAPHICAL SKETCH

Rita Lawler Goodman was born in Pittston, Pennsylvania on March 28, 1953. She graduated from Villanova University in 1975 with a degree in psychology. After graduating she worked at Luzerne County Mental Health Center, Wilkes Barre, Pennsylvania as a mental health therapist and later as a clinical coordinator. In August, 1979, she graduated from the University of Scranton with a master's degree in rehabilitation counseling.

In 1980 she married Ira J. Goodman and moved to Gainesville, Florida. Rita was employed as a clinical coordinator at S.P.A.R.C. in Gainesville from 1980-1981. From 1981 through 1983 she held a position as a mental health therapist at the Tri County Mental Health Center, Bronson, Florida. During this time she returned to graduate school at the University of Florida to pursue a graduate degree in counselor education.

Rita moved to Orlando, Florida, in 1983 and joined the Green House Counseling Center as a marriage and family therapist. She received her Ed.S. degree in 1985, and continued graduate work toward a Ph.D. in counselor

education. In 1985 she began employment at PRU-Care, Orlando, Florida as a marriage and family therapist.

Rita presently is in private practice in Orlando, Florida. She is licensed as a marriage and family therapist and a mental health counselor, and is a clinical member of the American Association for Marriage and Family Therapy. Rita, her husband, and their son reside in Heathrow, Florida.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Ellen S. Amatea
Professor of Counselor Education

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